DOCUMENT RESUME

ED 340 472 PS 020 150

TITLE	Generating Innovative Strategies for Healthy Infants and Children. Hearing before the Select Committee on Children, Youth, and Families. House of Representatives, One Hundred Second Congress, First Session.
INSTITUTION	Congress of the U.S., Washington, DC. House Select Committee on Children, Youth, and Families.
REPORT NO	ISBN-0-16-035794-2
PUB DATE	23 Apr 91
NOTE	130p.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328 (Stock No. 052-070-06776-4, $4.00).
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	*At Risk Persons; Birth Weight; *Child Health; *Delivery Systems; Drug Use; Federal Programs; Health Insurance; Health Personnel; Health Programs; *Health Services; Hearings; *Infant Mortality; Low Income Groups; Nutrition; *Prenatal Influences; Unwed Mothers
IDENTIFIERS	Childhood Illnesses; Congress 102nd; Maternal Health; *Prenatal Care

ABSTRACT

In this report of a hearing on infants' and children's health, two factsheets present information on the lack of recent progress in reducing infant mortality rates; the accessibility of prenatal care; low birthweight; nutrition; inadequate child health care; health risks for low-income children; the lack of adequate health insurance; the health care provider shortage; inflexibilities of the medical system; the limits of technology in addressing the issue of infant mortality; the relationship of maternal behaviors and characteristics, such as drug use and marital status, to infant mortality; and the need for services that remove unnecessary bureaucracy from the health care system. Statements were made by nine representatives and by Senator Bill Bradley. Statements or other materials were presented by six other individuals representing organizations or government agencies. Topics included those covered in the factsheets and one-stop shopping for health care services, an outbreak of measles, and Bush administration initiatives to address the problem of providing child health care. (BC)

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GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN

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HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 23, 1991

Printed for the use of the
Select Committee on Children, Youth, and Families

PS 020150

U.S. GOVERNMENT PRINTING OFFICE
43-680 WASHINGTON : 1991

For sale by the U.S. Government Printing Office
Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328
ISBN 0-16-035794-2

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GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN

TUESDAY, APRIL 23, 1991

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The committee met, pursuant to call, at 10:00 a.m., in room 340, Cannon House Office Building, Hon. Patricia Schroeder [chairwoman of the committee] presiding.

Members present: Representatives Schroeder, Miller, Rowland, Skaggs, Collins, Peterson, Cramer, Wolf, Walsh, Machtley, Bilirakis, Klug, Camp, and Barrett.

Staff present: Karabelle Pizzigati, staff director; Jill Kagan, deputy staff director; Madlyn Morreale, research associate; Danielle Madison, minority staff director; Carol Statuto, minority deputy staff director; Elizabeth Maier, professional staff; and Joan Godley, committee clerk.

Chairwoman SCHROEDER. I'm going to go ahead and call the hearing to order, and we want to welcome this morning our distinguished friend from the Senate.

First, let me ask unanimous consent to put my statement in the record, and I want to put this hearing in a little bit of context.

In 1989, the Assistant Secretary for Health James O. Mason testified before this committee that we have the knowledge to save at least 10,000 of the 40,000 infants who die yearly in this country, and that the failure to act on that knowledge costs us over $2 billion annually, in the care of critically ill infants.

We're going to be talking today about a variety of things that have been out there. How hard is it to do planning and coordination? We've known for years that planning and coordination would certainly help people trying to deal with all these different services.

This committee has looked for family-friendly services all across the board, and we certainly have not found them in the child and maternal health area.

We will be hearing from the Administration about their new policy to consolidate. We have a concern that the plan still isolates a lot of the health services, so it doesn't look like the total coordination that we had hoped for.

As you know, there was also the ten-city targeted approach to deal with infant mortality that the Administration announced, and the Congress challenged because to get the money for those ten

cities, they were taking it from the very, very critical community health centers that were also helping prevent infant mortality.

So, we've seen all sorts of different approaches, and it gets very frustrating that we've not been able to do a better job of getting results.

We know that the proportion of low birthweight babies has not improved in nearly a decade. We know that the measles epidemics in inner cities should send very strong warning signals to us that we are not putting our money into some of the most basic preventative care that we could have.

We can't be surprised because nearly 15 million women have no health care coverage for maternity care. That obviously shows up then, in the type of pregnancy treatments that they get. Then we see with the services, the lack of child care, transportation, and on, and on, and on, and on—people just get whipped around in the system all over the place.

So, we're very pleased today that our colleague, Senator Bradley, who has been a member of the National Commission to Prevent Infant Mortality, is here to unveil this new commission report that has a blueprint for what this country could do—it is not more dollars, it is more efficiency—as they highlight once again the "one-stop shopping" programs and the "family-friendly" programs.

We are also fortunate to have a member of our own Select Committee, Congressman Roy Rowland, who is on this commission, and he will be coming a little later. He is both a physician and a policymaker, and he's been absolutely invaluable.

We've got other distinguished witnesses we'll be hearing from this morning, and I will allow Mr. Wolf to put in his statement, and anyone else who wants to put in their statement, at this time, and I think we'll move along and open it up to you.

[Opening statement of Chairwoman Patricia Schroeder follows:]

OPENING STATEMENT OF CHAIRWOMAN PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO, AND CHAIRWOMAN OF THE SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

In 1989, Assistant Secretary for Health James O. Mason testified before the Select Committee on Children, Youth, and Families that we have the knowledge to save 10,000 of the 40,000 infants who die each year, and that the failure to act on that knowledge costs over $2 billion annually in the care of critically ill infants.

The Administration's recent actions speak louder than words. At first glance, the recently announced plan to reorganize children's services within the Department of Health and Human Services suggests elevating children's issues to new heights. But the approach flies in the face of Dr. Mason's declaration that we know what to do and how to do it. Instead of promoting unity and coordination at the federal level to improve child health, the plan isolates the Maternal and Child Health Services Block Grant from other public health programs, including community and migrant health centers, the National Health Service Corps, childhood immunization, lead screening, and others that are so crucial to child health and well-being.

Such action follows the Administration's announcement of an "infant mortality initiative" in the President's budget proposal. He suggested paying for a ten-city targeted approach by pilfering critically needed funds from community health centers. Congress took immediate action and rejected his funding proposal and provided new money because we need leadership and far-reaching reform in our health care system—not smoke and mirrors.

Now they tell us progress has been made in reducing infant deaths—the preliminary infant mortality rate for 1990 dropped to 9.1 infant deaths per 1,000 live births. But the fact that we are saving critically ill newborns with costly high technology rather than ensuring that babies are born healthy in the first place tempers that success.

The proportion of babies born too small has not improved in nearly a decade. Neither has the percentage of pregnant women who receive prenatal care in the critical first trimester of pregnancy.

The recent measles epidemics in inner cities across the country should also send warning signals that the youngest, most vulnerable children are not getting the basic care they need.

This should not surprise us because nearly 15 million women have no health insurance coverage for maternity care, and over 9 million children have no health insurance. Insurance protection, while absolutely essential to health care access, however, will not by itself ensure that all women and children get the preventive health care they need.

Lack of child care, limited transportation, a shortage of health care providers, especially for Medicaid recipients and those living in rural areas, language and cultural barriers, and a bureaucratic maze make access to services so unwieldy that families just can't get them.

Dr. Mason was right. We do know what to do. We are just not doing it.

I am very pleased that today, our colleague Senator Bill Bradley, a Member of the National Commission to Prevent Infant Mortality, will release a new Commission report that gives us a blueprint for action by highlighting one-stop shopping programs—defined broadly in terms I like to think of as "family friendly"—that work at the state and local level.

We are fortunate to have as a member of our own Select Committee, Congressman Roy Rowland, who also sits on the National Commission. As a physician and a concerned policymaker, his service here and on the Commission has been invaluable.

We will also hear from Judith Jones, Director of the National Center for Children in Poverty, who will further enlighten us about promising strategies to improve child health for the most vulnerable children, and Kay Johnson of the March of Dimes, who will discuss their organization's perspective of what it will take to ensure that all children get a healthy start in life.

I am especially pleased that we will have testimony from those on the frontlines who work with and for families everyday, helping them gain access to an often fragmented patchwork of services.

Thank you all for coming today. I look forward to your testimony.

GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN

A FACT SHEET

INFANT DEATH RATE, PRENATAL CARE USE SHOW LITTLE OR NO PROGRESS

- In 1988, nearly 39,000 U.S. infants died before their first birthdays. The infant mortality rate (IMR) was 10.0 deaths per 1,000 live births. African-American infants were twice as likely to die than white infants, with IMRs of 17.6 and 8.5 respectively. (National Center for Health Statistics [NCHS], 1990)

- Low birthweight is the greatest determinant of infant death and disability. In 1988, 6.9% of all infants were born at low birthweight (LBW), or less than 5.5 lbs., unchanged from the previous year. Among African-American births, the incidence of LBW was 13.0%, the highest level since 1976, compared with 5.6% of white births and 7% of births to Hispanic mothers. (NCHS, 1990)

- The proportion of mothers receiving early prenatal care has remained stagnant since 1979. In 1988, nearly one-fourth (24%) of babies was born to mothers who did not begin prenatal care in the critical first trimester. Among African-American mothers the rate was 39%. (NCHS, 1990)

COMPREHENSIVE/ACCESSIBLE PRENATAL CARE, NUTRITION CRUCIAL FOR HEALTHY DEVELOPMENT

- In a North Carolina study of 758 low-income women, pregnant women on Medicaid who received private practice physician care were 57% less likely to receive the benefits of the Special Supplemental Food Program for Women, Infants, and Children (WIC) and 2.3 times more likely to have a low birthweight baby than women who received prenatal care at the public health department's comprehensive care program. (Buescher, et al, 1987)

- In a study of over 21,000 North Carolina births to Medicaid recipients, women not receiving services coordinating maternity care had a low birthweight rate 17% higher and a neonatal mortality rate 39% higher than those receiving coordination services. (Select Committee on Children, Youth, and Families, 1990)

- Pregnant women on Medicaid who are not WIC participants are 2-3 times more likely to receive inadequate prenatal care than those on both Medicaid and WIC. (Klerman, 1991)

- Prenatal participation in WIC is associated with Medicaid savings ranging from $1.77 to $3.13 for newborns and mothers for every WIC dollar expended. (U.S. Department of Agriculture, 1990)

- Low birthweight babies are 49-64% more likely than normal weight infants to attend special education classes. In 1989-90, special education costs due to low birthweight were $370.8 million. (Chaikind and Corman, 1990)

MILLIONS OF AMERICAN CHILDREN RECEIVE INADEQUATE CARE

- Approximately 7 million U.S. children do not receive routine medical care. In 1986, 37% of children ages 1 to 5 in families below the poverty line had not seen a physician within the past year, compared with 16% of children living in families with incomes above 150% of the poverty level. Health survey data from 1988 show improvement, but access problems have not been eliminated. (National Association of Children's Hospitals and Related Institutions, 1989; Klerman, 1991)

- Between 1985-1987, urban white children in fair or poor health averaged 16.4 physician contacts per year, while their rural counterparts averaged only 13.1. Similarly, urban black children in fair or poor health averaged 6.9 annual visits, compared with five visits in rural areas. (Center on Budget and Policy Priorities [CBPP], 1991)

- Immunization rates for preschool children against diphtheria, tetanus, and pertussis (DTP) average 41% higher in many Western European countries than in the United States, and mean polio immunization rates are 67% above U.S. figures. In 1990, more than 25,000 cases of measles were reported in the U.S., almost 17 times the all-time low number of cases reported in 1983, resulting in over 60 deaths. Almost half (47%) of these cases were reported among preschool-age children. (Williams, 1990; National Vaccine Advisory Committee, 1991)

LOW-INCOME CHILDREN FACE GREATER RISK OF POOR HEALTH

- Low-income children are about twice as likely as higher-income children to be born at low birthweight, two to three times more likely to experience postneonatal mortality, and three times more likely to have delayed immunizations and lead poisoning. (Starfield and Newacheck, 1990)

- One child in six has dangerously elevated blood lead levels (above 10ug/dL), including 50% of all poor African-American children. Lead exposure is associated with severe retardation, lower IQ, speech and language impairments, learning disabilities, and poor attention skills. (Needleman, 1990)

- Over 5 million children under age 12 suffer from hunger, and another 6 million are at risk of hunger. Hungry children are two to three times more likely than children from non-hungry low-income families to suffer from health problems, including unwanted weight loss, fatigue, headaches, inability to concentrate, and irritability. (Food Research and Action Center, 1991)

- In a 1985 New York City hospital discharge study, among children ages 1-4, rates for cellulitis, pneumonia, otitis media, and upper respiratory infections were about three times as high in areas with the largest proportion of population below poverty than those in the least poor areas; asthma and bronchitis rates were over four times higher. (Klerman, 1991)

MILLIONS OF WOMEN AND CHILDREN LACK HEALTH INSURANCE, RISK POOR HEALTH

- In 1988, approximately 32 million non-elderly Americans lacked health insurance. The uninsured are 33% more likely to be in fair or poor health and nearly twice as likely to lack a regular source of health care as those with health insurance. (General Accounting Office [GAO], 1991; Freeman and Blendon, 1987; Robert Wood Johnson Foundation, 1987)

- Of the 9.2 million children who lacked health insurance in 1988, nearly two-thirds were living in families with full-year, never unemployed parents; 6.8 million were living in households with incomes between 100-399% of poverty. (Employee Benefits Research Institute, 1990)

- Fifteen million women (26%) in their child-bearing years (15-44) have no health insurance coverage for maternity care; 9.5 million women (17%) in this age group have no insurance at all. Two-thirds of women without health insurance do not begin prenatal care in the first trimester, compared with one-fifth of privately insured women. (GAO, 1987; American Academy of Pediatrics, 1989)

- Babies whose parents have no health insurance are 30% more likely than those from insured families to die or be seriously ill at birth, according to a study of more than 100,000 births in the San Francisco Bay area. (Braveman, 1989)

HEALTH CARE PROVIDER SHORTAGE LIMITS HEALTH CARE ACCESS

- Every year, about 215,000 births (6%) occur in 799 counties with no identified clinic provider; 110,000 women give birth in counties with neither a clinic providing prenatal care nor an office-based obstetrician-gynecologist (ob/gyn). (Singh, Forrest and Torres, 1989)

- In 1988, nearly two-thirds (62%) of rural counties reported having no obstetrician and a slightly greater number reported having no pediatrician. The number of pediatricians (per 100,000 women of childbearing age) was more than three times higher in urban areas than rural areas. (CBPP, 1991)

- In a survey of 32 Michigan health departments, 69% of respondents cited provider unwillingness to participate and nearly half (44%) cited inadequate advertising as primary reasons for client under-enrollment in the State Prenatal/Postpartum Care program. (Miller, et al, 1989)

UNAFFORDABLE, UNRESPONSIVE, INFLEXIBLE MEDICAL SYSTEM IMPEDES ACCESS

- Among 15 studies reviewed, inhospitable institutional practices and financial barriers emerged among the top five reasons for obtaining insufficient care. When insurance status and financial factors are controlled and services are accessible, differences between poor and nonpoor families' utilization of health care almost completely disappear. (Institute of Medicine, 1988; Klerman, 1991)

- A recent survey revealed that a third of Medicaid application sites studied had no special service for Spanish-speaking clients. (National Coalition of Hispanic Health and Human Services Organizations, 1990)

- Attitudinal barriers were cited by 39% of surveyed women who obtained inadequate care: 22% cited fear of doctors and medical exams; 10% cited fear of arrest or deportation; 10% cited cultural biases against male providers. (GAO, 1987)

- Transportation difficulties were cited as a factor in preventing women from receiving adequate prenatal care by 38% of surveyed ob-gyns and 23% of interviewed women who received inadequate care. (American College of Ob/Gyns [ACOG], 1988; GAO, 1987)

- Limited child care was cited in not obtaining sufficient prenatal care by 24% of surveyed ob-gyns and 16% of surveyed women; inability to arrange time off from work was cited as a factor preventing women from getting adequate prenatal care by 14% of surveyed ob/gyns and 7% of surveyed women. (ACOG, 1988; GAO, 1987)

April 23, 1991

[Opening statement of Hon. Frank Wolf follows:]

OPENING STATEMENT OF HON. FRANK R. WOLF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA AND RANKING MINORITY MEMBER, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

I commend Chairwoman Schroeder for having this hearing today and continuing the Select Committee's commitment to making a positive difference in the lives of pregnant women and their young children.

America is being shown in no uncertain terms by nearly all its family statistics that the family and well-being of its children are facing some pretty tremendous obstacles. Overcoming high infant mortality rates in this country, particularly in urban areas, is one such obstacle. Although our infant mortality rates have declined each year, the number of babies who die as a result of low birthweight in this country is still, quite sadly, very high.

As Health and Human Services Secretary Louis Sullivan pointed out a few weeks ago, infant mortality continues to linger at high levels for a number of reasons, including the breakdown of the American family. Medical experts are now beginning to find that infant mortality levels are significantly affected by whether or a baby is born into a one- or two-parent family. According to the *New England Journal of Medicine*, both black and white unmarried women have a substantially higher risk of having infants with very low or moderately low birthweights. It is already very difficult today to juggle the demands of time and money in a two-parent family; when a woman has to carry a baby to term by herself, work, and raise the infant alone, the health of her and her baby can be seriously jeopardized.

Our babies and their mothers deserve better. By developing policies that will support and sustain the family as one of the most valuable resources of society, the health of our nation and its babies will only stand to benefit.

In addition to recognizing the importance of the family in ensuring the health of our babies, there are two other issues that relate directly to our efforts to battle infant mortality. One issue involves the lack of integration of maternal and health services for pregnant women and their babies. The other involves the behavior of individuals and how important the efforts of pregnant women, health care providers, neighborhoods, the private sector and those involved in public policy are to improving our nation's infant mortality rate.

The President and the Congress have increased funding for the Women, Infants, and Children (WIC) program, the Maternal and Child Health Block grant and other maternal programs, and expanded Medicaid eligibility. But, maternal and child health services are still for the large part delivered in a fragmented, uncoordinated manner. As this year's report of the National Commission to Prevent Infant Mortality shows and as our distinguished witness Congressman Tom Bliley will point out today, the lack of integration of services for pregnant women and their babies presents a real barrier to improving our infant health and mortality rates in this country. By providing comprehensive one-stop-shopping for prenatal care, access will be increased as well as motivation among pregnant women to receive proper prenatal care.

Providing one-stop shopping for prenatal care services will build some important "bridges" necessary to reducing infant mortality. But, one-stop shopping is not sufficient to end infant mortality. We must also acknowledge another vitally important component to improving the health of a pregnant woman and her child. As Dr. Sullivan points out, each and every one of us has a personal responsibility for our own health and that of our babies. Doctors and others specializing in this area are beginning to cry out that in addition to receiving prenatal care services and proper nutrition, it is critical that the pregnant woman commit herself to choosing behavior that will be healthy for her and her baby.

If a pregnant woman chooses dangerous behavior such as smoking crack cocaine, smoking cigarettes, drinking excessive amounts of alcohol, or not participating in parental care, all our attempts at essential services and care are threatened and undermined. For example, 25 percent of pregnant women continue to smoke, and smoking is the leading cause of preventable low birthweight.

The District of Columbia is an example of how wide availability of funds and services cannot alone produce the results intended. The District of Columbia has visible media campaigns, outreach programs, and even integrated services and, yet, each year D.C. has one of the nation's worst infant mortality rates. According to Dr. T. Berry Brazelton, cities with high infant mortality rates are also cities with very high maternal use of drugs during pregnancy. It is estimated that 25 percent of babies born in D.C. are to addictive mothers. One of the goals of the Administra-

tion's "Healthy Start" program that Dr. Robert Harmon will discuss today is helping women avoid the addictive behaviors that contribute to infant death and disease.

Infant mortality and low birthweight are multi-faceted problems and building bridges to help our nation's mothers and their children will require the efforts of many. We need support for the family through public policy, integration and adequate funding of prenatal care services, and individual accountability of expectant parents. We need the rich resources that come from all sorts of individuals: from extended family, health care providers, clergy, a caring community, the private sector, public officials, and parents-to-be, working together to make a difference in the lives of our nation's infants. As Ann Brown, a neonatology nurse at George Washington who commits every day to helping mothers and their at-risk infants, says, "Change is possible, I cannot be an island, I cannot be neutral."

I look forward to hearing each of the witnesses today and to learning more about how each of us can work to be "less of an island" in our efforts to improve the health and well-being of our nation's infants and children.

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U.S. House of Representatives

SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, DC 20515-6401

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April 23, 1991

MINORITY FACT SHEET

"GENERATING INNOVATIVE STRATEGIES FOR HEALTHY INFANTS AND CHILDREN"

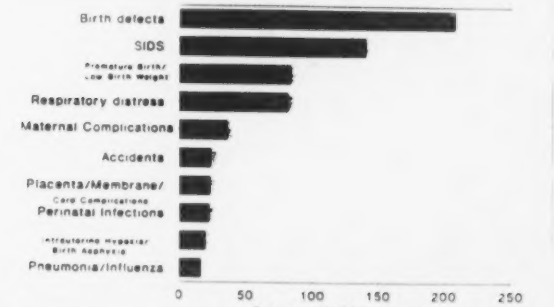
I. THE LIMITS OF TECHNOLOGY IN ADDRESSING INFANT MORTALITY

- The 1990 provisional infant mortality rate is 9.1 infant deaths per 1,000 live births, a drop below the provisional estimate of 9.7 percent for 1989. **The 1990 rate of 9.1 represents the biggest single-year decline in a decade.** (Statement by Secretary of Health and Human Services Dr. Louis Sullivan, April 8, 1991, p.2)

- The decline of infant mortality rates in the 1970s has been **attributed largely to the invention of medical technology** for the care of premature and other critically ill newborns. In the 1980s, this decline has slowed tremendously -- partly because of a lack of progress in primary prevention of conditions which lead to infant death. (Center for Disease Control, Morbidity and Mortality Weekly Report, September 22, 1989, Vol. 38, No. 37, page 635. Public Health Service, U.S. Department of Health and Human Services.)

- In the past 25 years, only a small proportion of the dramatic reduction in infant mortality has been due to a reduction in the prevalence of low birth weight. The approximately twofold higher infant mortality rate of blacks as compared with whites is due primarily to their different rates of delivering preterm low-birth-weight infants, particularly those weighing less than 1500 grams. (Editorial, The New England Journal of Medicine, Vol. 317, No. 12, p. 763)

Leading Causes of Infant Mortality, 1988

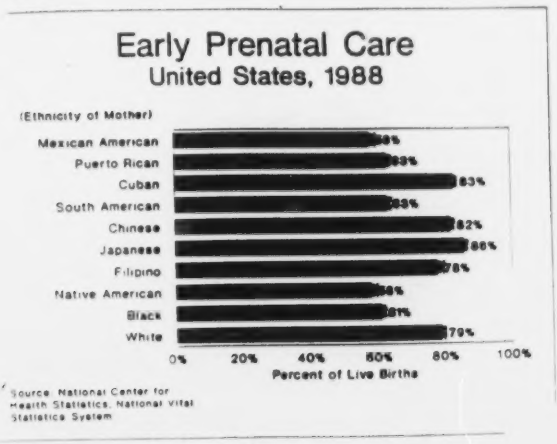


Source: National Center for Health Statistics

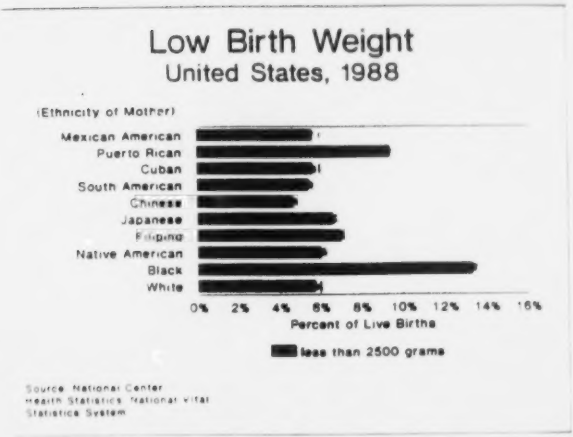
- The leading causes of infant mortality in 1988 were birth defects, sudden infant death syndrome (SIDS), low birth weight, and respiratory distress. [See chart above] These top causes can in many cases be linked to aberrant behavior during pregnancy. For example, a number of the risk factors related to SIDS are maternal smoking and drug use, teenage birth and infections late in pregnancy. (Healthy People 2000, Maternal and Infant Health, p. 369)

- The low birth weight distributions among various ethnic groups correlates with the infant mortality rates of each of these ethnic groups. (See graph "Low Birth Weight" and "Infant Mortality Rates" below)

- The link between early prenatal care and infant mortality rates only tells part of the story of infant mortality rates. For example, despite comparable or higher levels of early prenatal care, Blacks (61 percent of whom had early prenatal care) had infant mortality rates of 18.7 per 1,000 live births compared to Mexican Americans (58 percent of whom had early prenatal care) who had 8.8 deaths per 1,000 live births. **The Mexican American infant mortality rate was even lower than the rate for Whites (9.0 deaths per 1,000 live births), despite the fact that Whites had a much higher incidence of prenatal care of 79 percent.** (See "Infant Mortality Rates" graph above, and "Early Prenatal Care" graph below)



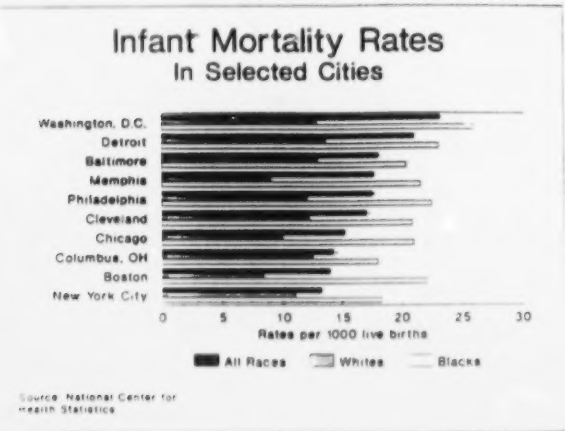
- In D.C., the infant mortality rate is three times the national average even though there is: free prenatal care to any woman whose family income is less than $20,000, eleven of the city's 16 health clinics provide prenatal care, there are maternity outreach programs that provide transportation to pregnant women and there are many private practitioners who cater to the Medicaid clientele. However, the all to frequent use of drugs or alcohol by women while pregnant undermines many of the services available. ("Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy


Low Birth Weight
United States, 1988
(Ethnicity of Mother)
Mexican American
Puerto Rican
Cuban
South American
Chinese
Japanese
Filipino
Native American
Black
White
0%
2%
4%
6%
8%
10%
12%
14%
16%
Percent of Live Births
less than 2500 grams
Source: National Center
Health Statistics, National Vital
Statistics System

Infant Mortality Rates
United States, 1983-1985
(Ethnicity of Mother)
Mexican American
8.6
Puerto Rican
12.3
Cuban
8
Japanese
6
Indian
13.9
Black
18.7
White
9
0
5
10
15
20
25
Deaths per 1,000 live births
Source: National Center
Health Statistics, National Vital
Statistics System

Review, p. 62).

- The cities with high infant mortality rates are also cities with very high maternal use of drugs during pregnancy. For example, it is estimated that 25% of babies born in D.C. are born to addictive mothers. (T. Berry Brazelton, Progressive Policy Institute seminar, 4/12/91, Washington, D.C.) (See "Infant Mortality Rates in selected cities" graph below)



II. **BEHAVIORAL ASPECTS OF HIGH INFANT MORTALITY RATES**

- "Studies of whites, blacks and Puerto Ricans all suggest that low-birth-weight births and very-low birth-weight births in the U.S. **correlate strongly with behavior, not nutrition, and especially with smoking, drug abuse (particularly the abuse of crack and other forms of cocaine), previous abortions, stress and infections of the genital tract and of the membranes surrounding the unborn baby, which often result from sexual promiscuity.**" (Dr. George Graham of John Hopkins University, Professor of Nutrition and Pediatrics, The Wall Street Journal, April 2, 1991).

- Over 5 million women of childbearing age (15-44 currently use an illicit drug, including almost 1 million who use cocaine and 3.8 million who use marijuana. (National Institute of Drug Abuse [NIDA], 1989).

- The National Commission to Prevent Infant Mortality has estimated that **smoking is responsible for about 25 percent of all low birthweight babies and about 4,000 infant deaths each year.** (Select Committee on Children, Youth, and Families, "Beyond the Stereotypes: Women, Addiction, and Perinatal Substance Abuse," Testimony of Reed Tuckson).

- "Women who use cocaine are likely to use other substances such as cigarettes, alcohol, and marijuana. They typically have other poor health habits such as poor nutrition and lack of prenatal care, all of which affect fetal outcome. Therefore, cocaine is only one of many factors in a woman's lifestyle that contributes to a low birthweight and small head circumference among infants prenatally exposed to cocaine." (Pediatric Nursing, March-April, Vol. 17, No. 2, p. 125)

- **Both black and white unmarried women had a substantially higher risk of having infants with very low or moderately low birth weights.** (Kleinman and Kessel, Racial Differences in Low Birth Weight, The New England Journal of Medicine, Vol. 317, No. 12, Sept. 17, 1987, p. 749)

- **"Unmarried mothers are more than three times as likely as married mothers to obtain late or no prenatal care.** Unmarried white mothers are almost four times as likely as married white mothers to obtain late or no care; and unmarried black mothers are twice as likely as married black mothers to obtain late or no care." (Prenatal Care: Reaching Mothers, Reaching Infants. Institute of Medicine, 1988, pp. 18-19.)

- In Japan, even though a woman is four times more likely to die during childbirth than a woman giving birth in the U.S. because of our complex medical treatment service, Japan still has the world's lowest rate of infant mortality - about half that of the United States. In Japan, less than 1 percent of all mothers are either unmarried or teenagers. ("Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, p. 63).

- **"Morbidity from infection is higher in the United States among those who are not breastfed, especially among the poor and the underserved...**Seventy-five percent of well-educated, middle to high income women breastfeed their infants. Less than 25% of low income women breastfeed their infants. Less than 25% of mothers in the WIC Program breastfeed their infants." (Testimony of Dr. Ruth Lawrence before the Senate Subcommittee on Antitrust and Committee on Agriculture,

March 14, 1991).

III. **THE NEED FOR INTEGRATED SERVICES THAT REMOVE UNNECESSARY LAYERS OF BUREAUCRACY AND FOCUS ON BEHAVIORAL CONTRIBUTIONS TO INFANT MORTALITY AND CHILD HEALTH**

- There are almost 100 federal programs administered by 20 federal agencies to address issues related to infant mortality. To state health care professionals, the burgeoning welter of agencies and programs related to infant mortality and prenatal care are more of a hindrance to their efforts than a help. ("Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, Spring 1990, p. 58)

- In 1990 the Department of Health and Human Services spent about $4.3 billion on health care financing, services, and research related to infant mortality problems. The U.S. Department of Agriculture (USDA) spent roughly $2.0 billion for special nutrition programs. States spent an estimated $2.3 billion for their share of state Medicaid programs and public health departments of all types provided prenatal care, well baby and immunization services. (White House Fact Sheet: The President' Initiative to Improve Infant Health, Febuary, 1991)

- "There is now ample evidence that patterns of miscommunication, poor coordination, and emphasis on function rather than on mission plague our maternal health care delivery system. Congress has chosen to take a piecemeal approach to the problem of infant mortality...But Congress failed to make any fundamental changes in the administration of these programs. Congress has failed to look at the effectiveness of programs both individually and as part of a comprehensive system...Instead of making choices, we just add another program...It is time to reconsider the service delivery system itself." (Rep. Thomas Bliley, "Reducing Infant Mortality: An Organizational Strategy, May 21, 1990)

- "The money to pay for prenatal care is already out there"...."what is often lacking is the commitment of people who deliver the services...the most effective way to deal with the problem of prenatal care is to take most of the money out of the purely public system and re-route it to other sources, be they private physicians or clinics like this. I think a little competition for the government is a healthy thing." (Maria Gomez of Mary's Center, "Stork Reality: Why America's Infants are Dying," Harmeet Singh, Policy Review, Spring 1990, p. 60.

- "Clearly our response to infant mortality must address the

social value system which leads to negative personal behaviors and irresponsible actions by expectant mothers and fathers...We will increase treatment programs dealing with the major behavior-related causes of infant mortality -- smoking, alcohol, drugs, poor nutrition and high-risk sexual behavior." (Secretary of Health and Human Services Dr. Louis Sullivan, Remarks to the National PTA Legislative Conference, March 11, 1991).

INFANT MORTALITY GLOSSARY
COMMONLY USED TERMS

CONGENITAL: Existing at birth.

FETAL DEATH: The product of conception, which, after separation from its mother, does not breathe or show other signs of life required to meet the World Health Organization's criteria for a live birth.

FETAL DEATH RATE: The ratio of fetal deaths to fetal deaths plus live births.

HIGH RISK: At greater than normal risk for contracting a specific disease or experiencing a condition.

IN UTERO: within the uterus.

INFANT MORTALITY: Death in the first year of life. About 1% of all babies born in the U.S. die in the first year of life. It includes neonatal mortality and postneonatal mortality.

INFANT MORTALITY RATE: The number of deaths among children under 1 year old per 1,000 live births in a given year. The infant mortality rate is the sum of two components: the neonatal mortality rate and the postneonatal mortality rate.

LIVE BIRTH: According to the World Health Organization, "the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite ovement of voluntary muscles".

(continued)
This definition is the basis for most States' requirements governing thereporting of live births.

LOW BIRTH WEIGHT: Birthwieght of lw=ess than 2,500 grams (5lbs. 8oz.).

LOW BIRTHWEIGHT RATE: Percentage of live births with birtheight of 2,500 grams or less.

MODERATELY LOW BIRTHWEIGHT: Birthweight between 1,500 and 2,500 grams.

NEONATAL: Pertaining to the first 4 weeks (28 days) after birth.

NEONATAL INTENSIVE CARE: Constant and continuous care of the critically ill newborn.

NEONATAL MORTALITY: Death in the first 28 days of life.

NEONATAL MORTALITY RATE: The number of deaths during the first 28 days of life per 1,000 live births.

NEONATE: A newborn infant less than a month old.

NEWBORN SCREENING: The process of testing asymptomatic newborn infants for diseases that require medical treatment.

NORMAL BIRTHWEIGHT: Birthweight of 2,500 grams (5lbs. 8oz.) or above.

PERINATAL: Pertaining to or occurring in the period shortly before and after birth, variously defined as beginning with the completionof the 20th to 28th wiik of gestation and ending 7 to 28 days after birth.

PREMATURE INFANT: Infants born usually after the 27th week and before full term; defined as an infant weighing 1,000 to 2,499 grams (2.2 to 5.5 lbs.) at birth, and having a poor to good chance of survival, depending on the weight.

PERINATAL CARE: Medical care pertaining to the perinatal period.

PRENATAL: Existing or occuring before birth, with reference to the fetus.

STILLBIRTH: The delivery of a dead child.

VERY LOW BIRTHWEIGHT: Birthweight of less than 1,500 grams (3 lbs. 5 oz.).

WELL CHILD CARE: Preventive health care for children, includingimmunization, phtsical examinations and other tests that screen for illness or developmental proviems, health education, and parental guidance.

Chairwoman SCHROEDER. Senator Bradley, we welcome you. We will put the statement into the record, and the floor is yours. We thank you for your very hard work on the commission.

STATEMENT OF HON. BILL BRADLEY, A U.S. SENATOR IN CONGRESS FROM THE STATE OF NEW JERSEY

Senator BRADLEY. Thank you very much, Madam Chairwoman, I appreciate the opportunity to testify, and I would ask if I could submit my whole statement to the record.

Chairwoman SCHROEDER. Without objection.

Senator BRADLEY. I'm very glad that you are dedicating this hearing to what I think is a uniquely important matter, and that is the health and well-being of infants, and children, and mothers.

I am a member of the National Commission to Prevent Infant Mortality, and I was pleased, as I'm sure you were, to see Dr. Sullivan's announcement of a reduction in the nation's infant mortality rate to 9.1 percent, on the front page of the newspaper, and the improvement, though it is small, is welcomed. I think that we still know what the facts are, however.

The facts tell us that there are thousands of pregnant women, who are not taking advantage of even the limited services available. Nearly 73,000 pregnant women in 1988, received no prenatal care at all—73,000.

How many of those women gave birth to one of the 40,000 infants that did not live through their first birthday? How many of them gave birth to one of the 50,000 very low birthweight babies, who are 40 times more likely to die and twice as likely to be blind, deaf, or mentally retarded?

It is not that we are not spending money on these babies. This nation may be spending as much as $2.5 billion to keep low birthweight babies alive, and I'm sure you, as well as I and every member of this committee, has visited a hospital intensive care room, where you've walked into a room full of incubators and seen a baby that is so small that you can put it in the palm of your hand, simply to make the point about the vulnerability of low birthweight babies.

And, so, it is not that we are not spending money, sometimes it is $150,000 or more just to keep one baby alive, but the cost of prenatal care for all of these unborn children, the $150,000 that you make up as you treat a baby in intensive care, could be as little as $500 million.

To save these children before they are born, we need to get their mothers to prenatal care and, if we can't do that, we need to deliver the prenatal care to them. We can't expect the pregnant woman, often very young—sometimes shockingly uninformed about her own body—to take six bus trips from one office to another to apply for Medicaid, to apply for WIC, to another office for housing, then to one clinic for a pregnancy test, to another for prenatal care and, later, a third clinic for immunizations.

The fact of the matter is, one-stop shopping is about bringing all these services together, where they are available to pregnant women most at-risk. It is a philosophy of infant health and nutri-

tion that says, "Make sure the services we are paying for, get to the people who need them". That's the way you break dependency.

It's about getting bureaucracy out of the way. It's about structuring services in terms of the people who need their help, rather than by what budget category or government department they happen to fall under.

The commission's report, which I have here and I'm sure that each of you have a copy of, or you will by the end the day, shows Federal, state, local, and nonprofit agencies how they can make one-stop shopping a priority in all the work they do.

There are several things that Congress can do to advance and perfect the concept of one-stop shopping. Under the Healthy Birth Act, one-stop shopping demonstration programs were authorized, but not funded.

By fully funding the Maternal and Child Health Block Grant programs, we would trigger funding for the demonstrations, the one-stop shopping demonstrations, and for home visiting programs.

And, Madam Chairwoman, I hope that we will be able to work together in making that a top priority in this year's appropriations because integrating services for mothers, infants, and children will make these programs more efficient, and enable community-based agencies to help all at-risk families in the most cost-efficient way.

So, I would urge that the committee read this report. It is very clear about the impact of one-stop shopping on dependence, and very clear about the impact of one-stop shopping on reducing levels of infant mortality. I mean, you'll see in here that where there have been programs like home visiting in states like North Carolina and Virginia, the infant mortality rate among the group that received the home visiting nurse was about 9 percent; among the group that did not, it was about 15 percent.

So, it makes a real impact, but the real question is, will they get adequate care whenever they go for the one-stop shopping? To stretch the metaphor of one-stop shopping out a little further, will there be products on the shelf? Will the prices be reasonable? Will there be a way to pay for them?

The best delivery system—and I believe one-stop shopping is the best—will not help if services that it delivers are inadequate. And that really brings me to the second reason that I wanted to testify before the committee today.

This week, I'll be introducing four bills that will help our nation become number one in keeping babies alive, and number one in feeding them and educating them after they are born. I hope the committee will take an active role in these four bills that reflect the most basic principles and values that we, as a society, must bring to bear where our children are concerned.

Now, what are those principles? Well, the first we've already talked about, one-stop shopping. Get the bureaucracy out of the way. Deliver the services to the people who need the services, so you can break dependency and make a difference in their lives.

Second, prevention. And, third, a stick that works. And, fourth, give every American who is concerned and willing to help, a way to get involved.

What about prevention? Well, in medicine, that has always meant immunization. It has meant conquering smallpox, polio, all

the other diseases that at one time took at least one child in nearly every family.

A few years ago, we thought we had conquered measles, for example. Then we began to see 18,000 cases of measles in this country in 1989, 25,000 cases of measles in 1990. We're beginning to see outbreaks of mumps, diseases for which there are vaccines and, inexplicably, diseases whose incidence is rising.

This epidemic of preventable, sometimes deadly, diseases is not so surprising when you realize that our immunization rate for kids under the age of 2 is worse than Nicaragua, or El Salvador, or Cuba.

To bring us up to the standards of the industrialized world, we need medical prevention. So, I'm introducing the Childhood Immunization Improvement Act and, in brief, the bill would do a couple of things. The match rate would go to 90 percent Federal, so that we wouldn't have to burden the states yet again.

It would increase the reimbursement rate under the EPSDT program, and it would allow health agencies to buy vaccines from the Centers for Disease Control at the bulk rate—in other words, lower cost.

For better prevention, however, we should also have better vaccines, and recent developments in biotechnology hold out the possibility of the development of something that I call the "Children's Vaccine". It is a single dose that would prevent a whole range of deadly diseases, and I suggest that we invest about $30 million more this year in research, and $60 million more by 1995, to bring this dream a reality.

Basically, the goal is to have not only a vaccine that is good for measles and mumps and those that are already in existence, but also to develop a vaccine for the diseases that are taking thousands and thousands of kids' lives in the Third World—rotavirus, streptococcus-B—to develop a vaccine that can be administered orally once in a child's life, that would permanently immunize the child against a wide range of diseases. This can be done with the proper investment in research. That's the bill that I'm speaking of.

The third bill I'm introducing this week would take one of the commission's best recommendations—that is, that we expand Medicaid eligibility for pregnant women, infants and children to 185 percent of the poverty line—and make it a reality.

We compromised before—we settled for 133 percent of poverty—and it made a difference. We got the improvement that Dr. Sullivan reported last week. There's no better way to make sure that kids get the medical attention they need. It's cost-effective, it works, and I don't think we should compromise on this anymore. We simply have to say, 185 percent of poverty.

So, you take one-stop shopping—it gets bureaucracy out of the way—you make a real investment in immunizations and in a children's vaccine, so that you can make the major investment in preventing these diseases in the first place, that endanger children in their early years and, finally, I'd like to set out a new way to fight an old fight.

For a long time, since I've been in the Senate, we have all agreed that there are a couple of programs, when it comes to children, that work—programs such as Head Start, the WIC program, Child

and Maternal Health—but as long as I have been in the Senate, those programs have never been fully funded. Head Start is funded at only about 25 percent in my state; WIC program about 38 percent funded; Child and Maternal Health, we're not even at the level of the full authorized block grant.

I know there are millions of Americans who feel as I do and would like to have these programs that work get proper funding. I also think many senior citizens in particular, are already volunteering for the Head Start program and for the WIC program. In my state, in number of counties, there are senior citizens coming in and volunteering in the Head Start program and in the WIC program. Many would like to do more.

These two facts—the great need for money and tough budgetary circumstances, and the apparent interest on the part of many senior citizens to become involved in the programs—has led to what I call the Children's Security Fund Act, which I hope will also provide resources for these programs.

What do I mean? Well, take Federal retirees, Social Security recipients, take what they receive annually; they get $300 billion in pensions.

What I would like to do is to allow them voluntarily, if they choose, to designate a portion of their pension check to one of those three programs—Head Start, WIC, Child and Maternal Health Block Grant. If one-half of 1 percent so dedicated, you'd increase funding for these programs by about 30 percent.

I know that I've talked a lot today, about—I guess it's all relative, not a whole lot—but I have talked about the One-Stop Shopping report, and the major pieces of legislation that I've introduced, and I wish there were some simple, single way to end infant mortality and to keep our kids healthy and educated, but when you meet some of the mothers at-risk, or you hold a low birthweight baby in your hand, you realize soon how many different kinds of family situations there are, and how many different threats there are.

So, the key is flexibility but, clearly, a thread of an answer has got to be found in the phrases "Get bureaucracy out from between the recipient and the dollars," "Invest in prevention," "Go with programs that you know work" and, in tough budgetary circumstances, try to find some innovative way such as allowing Social Security and military and Federal pensioneers designate a portion of their check to programs that work.

Madam Chairwoman, I thank you very much for the chance to testify, and would be prepared to answer any questions that you might have.

[Prepared statement of Senator Bill Bradley follows:]

PREPARED STATEMENT OF SENATOR BILL BRADLEY, A U.S. SENATOR IN CONGRESS FROM THE STATE OF NEW JERSEY

Madam Chairwoman, I am very glad that you are dedicating one of your first hearings as chair of this uniquely important committee to a matter of our national survival—the health and well-being of America's mothers, infants, and children.

As a member of the National Commission to Prevent Infant Mortality, I was as pleased as I'm sure you were to see Dr. Sullivan's announcement of a reduction in the nation's infant mortality rate to 9.1% on the front page of the newspaper. The improvement, though small, and even though there has not been a comparable re-

duction in low-birthweight babies or women who lack prenatal care, tells me that the Commission is on the right track. To the extent that Congress has enacted its recommendations, such as expanding Medicaid eligibility for pregnant women, they have worked. It makes sense to keep going. And the fact that it is front page news, the fact that Americans no longer close their eyes to the tragic reality that cities like Camden, New Jersey, have an infant mortality rate equal to Panama's, tells me that we have the national will to implement all the Commission's recommendations and give all babies a chance at life.

We should all be grateful to the Commission for its very practical, clear-headed approach to keeping babies alive. The Commission's newest report, "One-Stop Shopping: The Road to Healthy Mothers and Children," continues that tradition. The best, most compassionate health and nutrition services won't reach the poorest pregnant women and the most vulnerable infants if they have to wade through a barrier of bureaucracy and transportation problems to get to them.

The facts tell me that many thousands of pregnant women are not taking advantage of even the limited services available. Nearly 73,000 pregnant women in 1988 received no prenatal care at all. Now many of those women gave birth to one of the 40,000 infants that did not live to their first birthdays? How many of them gave birth to one of the 50,000 very low birthweight babies who are 40 times more likely to die and twice as likely to be blind, deaf, or mentally retarded?

It's not that we're not spending money on these babies. This nation may be spending as much $2.5 billion to keep low birthweight babies alive. It's that we're spending the money at the wrong time. The cost of prenatal care for all these unborn children could be as little as $500 million.

To save these children before they are born, we need to get their mothers to prenatal care. And if we can't do that, we need to deliver the prenatal care to them. We can't expect a pregnant woman, often very young, sometimes shockingly uninformed about her own body, to take six bus trips from one office to another to apply for Medicaid, to apply for WIC, another office for housing, then to one clinic for a pregnancy test, another for prenatal care, and later a third clinic for immunizations.

One-stop shopping is about bringing all these services together where they are available to the pregnant women most at risk. It's a philosophy of infant health and nutrition that says, make sure the services we're paying for get to the people who need them. It's about getting bureaucracy out of the way. It's about structuring services in terms of the people who need their help, rather than by what budget category or government department they happen to fall under.

The Commission's report shows federal, state, local, and nonprofit agencies how they can make one-stop shopping a priority in all the work they do. There are several things that Congress can do to advance and perfect this concept, though. Under the Healthy Birth Act, one-stop shopping demonstration programs were authorized, but not funded. By fully funding the Maternal and Child Health Block Grant program, we would trigger funding for the demonstrations and for home-visiting programs. I hope we can work together in making that a top priority in this year's appropriations.

Integrating services for mothers, infants and children will make these programs more efficient and enable community-based agencies to help all at-risk families in the most cost-effective way. I believe it will mean that we can look forward to a day when there are virtually no pregnant women who receive zero prenatal care. But will they get adequate care? To stretch out the one-stop shopping metaphor a little further, will there be products on the shelves? Will the price be reasonable? Will there be a way to pay for them? The best delivery system—and I believe one-stop shopping is the best—will not help if the services it delivers are inadequate.

That brings me to the second reason I wanted to speak to this committee today. As you know, we have only made small steps toward ensuring that every child in America has a chance to grow up healthy and educated. For example, we now offer Medicaid assistance to pregnant women with incomes below 133% of the poverty line. That's a big improvement over a few years ago, when a mother-to-be with an income of barely one-third of the poverty level was ineligible for help in some states. But we're still not preventing those deaths from hunger, disease, and low birthweight.

This week I will be introducing four bills that will help our nation become number one in keeping babies alive, and number one in feeding them and educating them after they're born. I hope this committee will take an active role in these four positive steps that reflect the most basic principles and values that we as a society must bring to bear where our children are concerned. What are those principles?

First, prevention. Second, stick with what works. Third, give every American who's concerned and willing to help a way to get involved.

Prevention, in medicine, has meant immunization. It meant conquering smallpox, polio, and all the other diseases that at one time took at least one child from nearly every family. A few years ago, we thought we had conquered measles. Then we began to see 18,000 cases of measles in 1989, 25,000 in 1990. We're beginning to see outbreaks of mumps and pertussis.

This epidemic of preventable, sometimes deadly diseases, is not so surprising when you realize that our immunization rate for kids under two is not much better than Haiti's. It's worse than in Nicaragua or El Salvador. To bring us up to the standards of the industrialized world in medical prevention, I am introducing the Childhood Immunization Improvement Act of 1991. In brief, this bill would change the federal reimbursement formula for immunizations to the formula used for other top priority programs; would increase the reimbursement rate under the EPSDT program; and would let health agencies buy vaccines from the Centers for Disease Control at a bulk price.

For better prevention, we should have better vaccines, and recent developments in biotechnology hold out the possibility of a "Children's Vaccine," a single dose that would prevent a whole range of deadly diseases. The economics of vaccines are such that pharmaceutical companies have little incentive to develop this super-vaccine, so my Children's Vaccine Initiative would provide $30 million this year, $60 million in 1995, to make this dream a reality.

The third bill I'm introducing this week would take one of the Commission's best recommendations—that we expand Medicaid eligibility for pregnant women, infants and children to 185% of the poverty line—and finally make it a reality. We compromised before—we settled for 133% of poverty, and it made a difference. We got the improvement Dr. Sullivan reported last week. There is no better way to make sure that kids get the medical attention they need. It's cost-effective. It works. I don't think we should compromise on this anymore, because we're not saving any money by doing so.

Finally, I'm setting out a new way to fight an old fight. For as long as I've been in the Senate, we've all agreed that there are two programs that really help kids grow up healthy and educated—the Women, Infants and Children nutrition supplement, and Head Start for early childhood education. But for as long as I've been in the Senate, we've never fully funded those programs.

I know that there are millions of Americans who feel as I do, who would like these programs that work for kids to be a top priority. Many senior citizens in particular are already volunteering in Head Start and in WIC programs. Many would like to do more. The Children's Security Fund Act would give some a way to do it. Federal retirees and Social Security recipients who judged for themselves that they could give back some of their benefits would be given the opportunity to help us build a Children's Security Fund which in turn would be used to finance WIC and Head Start. I don't expect that an overwhelming number of recipients of the $300 billion we spend annually on retirement would be able to contribute to increase the mere $5 billion we spend on young children, but consider this: If just one-half of one-percent of federal retirement funds were given back, we could increase the children's programs by about 30 percent. It's a way to let those who want to help children get involved.

I know I've talked about a lot today—a major report and four pieces of legislation. I wish there were some single, simple way to end infant mortality and keep our kids healthy and educated. But when you meet some of the mothers at risk, or hold an underweight infant, you realize soon how many different kinds of family situations there are, and how many different threats. If you've had a chance to read Sylvia Ann Hewlett's wonderful new book, "When the Bough Breaks: The Cost of Neglecting Our Children," you know about Cinde Guzman, a 33-year-old married graphic designer who had to wait until six months into her pregnancy before she could scrape together the thousand dollars that every doctor she saw wanted up front for a prenatal exam. Her baby was born weighing 2.6 pounds, and the state insurance fund paid the $150,000 of care it needed. And you've met Dorothy Mason, a 17-year-old who is trying to finish high school while taking care of her baby, earning just enough for Pampers and baby powder, and trying to hold onto her dream of going to college.

These mothers are trying to do the best they can for their kids in the face of a system that doesn't provide much help, and doesn't make it easy to find the help that's there. We know what we have to do: Get bureaucracy out of the way. Expand the programs that work. Make prevention a priority. And let those who want to

help participate. I hope you'll join me and the Infant Mortality Commission in this crusade for healthy kids.

Chairwoman SCHROEDER. Thank you very much, Senator. We're very honored that you came over. I know what we certainly find in Denver, and I'm sure you find everywhere, the increasing number of babies who are born in emergency wards, and that's the first time anyone sees them. So, I really appreciate that and all your innovative ideas.

Normally, the Chair calls on people in order of how they came, so we are very, very democratic—with a small "d"—committee. But I do see that we have the very distinguished member of our panel who was on the commission with you and, if everybody will forgive me, let me ask Dr. Rowland if he has anything that he would like to add first, because I know he was one of your panel members, and we're very happy to have him here.

Mr. ROWLAND. Thank you very much, Madam Chairman, and I apologize for being late.

Senator Bradley, I really do appreciate you being here today, and I've been very pleased to have the opportunity to work with you as a member of the National Commission to Prevent Infant Mortality.

I guess one of the most important messages which the commission has tried to convey is that we must insure that all women receive prenatal care. We ought to reduce our infant mortality rate, and prenatal care means more than medical services. It includes a range of services which respond to health, nutritional, social, and other needs of the mothers. And I guess the best insurance for a family is a healthy pregnancy and a mother who is prepared for parenthood.

And a child who receives appropriate health care has a good chance of growing up healthy, learning in school, and becoming a productive member of society. Tragically, this does not happen for many mothers and children today.

We all know the statistics about high infant mortality, low birthweight rates, women who receive little or no prenatal care, and I certainly did experience that when I was delivering babies, when I was in family practice and, of course, the lack of immunization of young children.

These figures are frustrating because we really know enough to turn them around, and the commission has tried to promote a number of effective strategies to do this. One-stop shopping is one of them.

I have a longer statement, and I would just ask that I be allowed to insert that in the record.

Let me say to you that I am so pleased that you have become the chairperson of this select committee. I have certainly enjoyed being a part of this over the years, and look forward to working with you and other members, to promote the interest of children and families.

Chairwoman SCHROEDER. Thank you. We appreciate all your hard work.

[Prepared statement of Hon. J. Roy Rowland follows:]

PREPARED STATEMENT OF HON. J. ROY ROWLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

I want to welcome my colleague, Senator Bradley, this morning. I have enjoyed working with you on the National Commission to Prevent Infant Mortality and appreciate your leadership in the Senate on infant mortality issues. Thank you for being here today to present the Commission's most recent report to the committee.

One of the most important messages which the Commission has tried to convey is that we must ensure that all women receive prenatal care if we are to reduce infant mortality. Prenatal care means more than medical services; it includes a range of service which responds to health, nutritional, social, and other needs of the mother. The best insurance for a family is a healthy pregnancy and a mother who is prepared for parenthood. And a child who receives appropriate health care has a good chance of growing up healthy, learning in school, and becoming a productive member of society.

Tragically, this does not happen for many mothers and children. We all know statistics on high infant mortality, low birthweight rates, women who receive little or no prenatal care, and the lack of immunizations of young children. These figures are frustrating because we know enough to turn them around. The Commission has tried to promote a number of effective strategies to help women understand the importance of prenatal and pediatric care and gain access to services.

One-stop shopping is one of the key strategies the Commission sees as critical to achieving the goal of universal access to care for mothers, infants, and children. We have all heard stories from constituents about difficulties and confusion encountered in applying for public assistance programs. The Medicaid program can be very frustrating and discouraging for recipients, doctors, clinics, and hospitals as well as for the administrators of the program.

The goal of one-stop shopping is to end these frustrations by creating a "user-friendly" health and social services delivery system. We now have many programs serving the same population, but they do not work together or have the same requirements, and their implementation at the local level is inconsistent. This is a multifaceted problem that we all can improve.

The Commission report discusses how this can be achieved through actions at all levels of government and in communities themselves. I think this report is one that everyone needs to act upon. Bill, I look forward to hearing your statement, and once again, thank you for joining us this morning.

Chairwoman SCHROEDER. Congressman Camp, do you have any questions?

Mr. CAMP. Thank you, Madam Chairwoman. I would just submit my statement for the record. Thank you.

[Prepared statement of Hon. Dave Camp follows:]

PREPARED STATEMENT OF HON. DAVE CAMP, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

I want to thank the Chairwoman for holding this hearing. As a new member of the Select Committee on Children, Youth and Families it is a pleasure to have this opportunity to take part in an examination of new strategies for improving the health care of our children.

I come from Michigan, a state that for all of its many resources continues to be losing important parts of its future because of a high infant mortality rate. This threat to our children and families does not respect boundary—urban and rural areas alike are caught in its grip.

This hearing comes at a time when Congress has an opportunity to make a dramatic breakthrough in how we confront this assault on our future. For years, Congress has taken important, meaningful steps to end the national disgrace of high infant mortality. But we have also come to realize that our successes have been marginal at best because we have followed a piecemeal approach that has further splintered a badly fragmented system. This year's report of the National Commission to Prevent Infant Mortality underscores this problem and should signal the need for real change. It does us no good to continually expand eligibility requirements or even increase funding for worthwhile programs when a bureaucratic maze continues to overwhelm patients and health care providers alike.

Dr. Sullivan has done a great service by laying down a challenging and realistic goal: a 50 percent reduction in infant mortality over five years in targeted communities where there is great need for improved health care for our children. To reach

that goal, we must improve the access to care, make it easier for our young mothers to obtain comprehensive care, increase our providers and make it easier for providers to participate. We must move to integrated services and coordinated care, the "one-stop shopping" approach we have heard so much about, to make certain that young mothers have immediate access to preventive services, prenatal and postpartum care. In that regard, I must thank my colleague, Congressman Bliley, for the great service he has done over the years in bringing attention to this need.

Healthy Start, President Bush's initiative, also takes into account the need for better coordination, as well as flexibility for states and communities to tailor services to specific community need, and the absolute need to make the application process for Medicaid and other programs easier and faster.

I am eager to hear the thoughts of our distinguished guests on these issues and others. We have the will—both the American people and the Congress—to end our infant mortality problem. It is my hope that this is the Congress that starts us on the road to getting the job done. And I look forward to hearing from you—our guests today—as to how we can best take the first steps.

Chairwoman SCHROEDER. Congressman Bilirakis, do you have anything you want to add?

Mr. BILIRAKIS. Madam Chairman, I have a statement that I ask unanimous consent might be inserted into the record.

Chairwoman SCHROEDER. Without objection.

[Prepared statement of Hon. Michael Bilirakis follows:]

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Madam Chairwoman, as a new member of the Select Committee on Children, Youth and Families, I am pleased to join you and my other committee colleagues to discuss the infant mortality issue, a matter in which I have a deep and personal interest. I also welcome members of the National Commission to Prevent Infant Mortality and look forward to hearing their recommendations on one-stop shopping.

Since 1989, I have served as the co-chairman of the congressional sunbelt caucus task force on infant mortality with my good friend, Roy Rowland. It has been a rewarding experience.

The purpose of the task force is to provide information on infant mortality to Congress, government agencies and public and private organizations. We have sponsored educational seminars for Congressmen and their staffs on upcoming health legislation, held panel discussions on medical malpractice, and even had a breakfast meeting with Health and Human Services Secretary Louis Sullivan to discuss infant mortality rates in the Southern States.

Task force members continue to be active on this issue because we are deeply concerned—the sunbelt region has the highest infant mortality rate of any area of the country. We want that statistic to change. In my home state of Florida, the infant mortality rate is disturbingly high—during 1987, 10.7 infants died before their first birthday out of every 1000 babies born. In my congressional district, the news is more encouraging—there has been a noticeable reduction in infant mortality rates for Pasco County since the mid-1980's.

The nutrition director of the Pasco County Health Department believes the county's aggressive special Supplemental Food Progam for Women, Infants and Children, better known as the WIC program, has greatly contributed to these reductions. Nutrition programs, which I strongly support, can make a significant difference in the lives of so many. I am proud to say the Pasco County program, in my opinion, goes that extra mile and while providing nutritional services, the staff takes a personal interest in every client.

Unfortunately, much more needs to be done to achieve our goal in completely eliminating infant mortality. The United States has the best medical technology in the world and, therefore, we have the ability to save many lives. If pregnant women had the necessary prenatal care, more and more healthy babies would be born and the need for expensive neonatal care would be sharply reduced.

Pregnant women need to know that prenatal and nutrition services are available to them. Many are intimidated by the numerous forms they are required to fill out or the many offices they must visit. I believe one-stop shopping would be the answer for those pregnant women who want to receive these services. There are those who do not seek out these services—women addicted to drugs, who abuse alcohol or those

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who do not understand the importance of prenatal and postnatal care. How do we solve this problem?

That is a difficult question to answer. I feel women need to understand the importance of these services, not only to them, but to the health of the baby. In the past couple of weeks, I have read two editorials that suggest infant mortality is not a result of malnutrition but is caused, instead, by behavior patterns. There is an element of truth to that statement, but I continue to believe that programs like WIC have been successful in combating malnutrition.

Our Government can put all the money it can into programs designed specifically for pregnant women but unless women want these services, we will not be successful. Once again, how do we solve this problem? I believe the first step is education—educating all persons, but especially our young people, about the dangers of smoking, excessive alcohol use and drug abuse. And it isn't the sole responsibility of the school system—churches, families and local leaders need to become involved as well.

If we could encourage these women, through education, to utilize these programs, not only will we have healthier babies but we will also have healthier mothers. Then programs such as one-stop shopping could make even a bigger difference in our national infant mortality statistics.

Madam Chairwoman, I look forward to hearing from our witnesses this morning about one-stop shopping and how it can contribute to lowering our infant mortality rate.

The following statistics, from the children's defense fund:
Florida is one of the ten worst States in the Nation on—
Low birthweight for all races;
Babies born to women receiving early prenatal care, all races;
Low birthweight, black;
Babies born to women receiving early prenatal care, black;
Babies born to women receiving adequate prenatal care, all races;
Babies born to women receiving late or no prenatal care, all races;
Babies born to women receiving late or no prenatal care, black; and
Babies born to women receiving inadequate prenatal care, all races.

Mr. BILIRAKIS. And to also say that I am pleased to join you and my other colleagues, particularly as far as this subject is concerned.

I've worked for the last two or three years, as co-chairman with Congressman Rowland, on the Task Force for Infant Mortality, and I always say back home, this is a fantastic learning experience up here. You spend a lot of time through the years, on civic affairs back home, and you think you've seen all of the needs, but God knows, it's only the tip of the iceberg. You come up here and you really see those needs.

I would just merely compliment the Senator and say that he's right on, and one-stop shopping is going to be a lot of help.

The problem, of course, is getting the people who need the care, to go to where the care is available, and one-stop shopping should be a lot of help there. I like to think we can probably complement that—we, by using our influence and maybe getting some of these volunteers involved, senior citizens and others, really getting them involved to even go into these areas, pick up these people and bring them to wherever the care might be located. That certainly is much of the answer, in addition to the things that you pointed out, Senator. Thank you.

And thank you, Madam Chairman.

Chairwoman SCHROEDER. And let me apologize, I didn't realize you were on the commission, too. I thank you for your hard work in representing——

Mr. BILIRAKIS. I'm not on the national commission as yet. I am on the task force, but I am making a great effort with Minority leader Bob Michel, to get appointed on the commission, be the Re-

publican member replacing Tom Tauke. I have high hopes in that regard.

Chairwoman SCHROEDER. We wish you well.

Dr. ROWLAND. He is certainly an appropriate person to be able to work with.

Chairwoman SCHROEDER. Congressman Cramer?

Mr. CRAMER. Thank you, Madam Chairman. I appreciate the opportunity for this committee to address this issue and, Senator Bradley, I appreciate your testimony here today.

I'm a new member of Congress, and my background has been that of being a prosecutor and, as a prosecutor down in Alabama, we faced many vulnerable families—mothers and parents who weren't prepared to be mothers and parents—and the systems that would try to deal with them were mainly bureaucratic. And, so, this effort to provide this one-stop shopping was something that we had to learn the hard way in the criminal justice system.

We reached out to those vulnerable families through innovative programs that would allow us to go to them rather than making them endure the bureaucracy there.

So, having said that, I have a question for you, somewhat fundamentally. Under this one-stop shopping plan, how are those neighborhood services delivered to these vulnerable parents?

Senator BRADLEY. There are varieties of ways to deliver one-stop shopping. One of them is essentially to have a place where someone can come to apply for a variety of programs. Another is through the so-called "case management" method, where you have someone who manages the case of one person and who, when he or she finds that they are eligible for and would benefit from a variety of programs, makes sure, as the case manager, that they get enrolled in those programs. The case manager facilitates enrollment in appropriate programs for which a needy person is eligible.

The third way is if you simply were able to hook up the information systems of the various bureaucracies where, once you were qualified for one, all the other computers would know that you were also qualified for all of the other programs, and it could be a kind of an automatic type of eligibility determination and enrollment.

Those are three of the possible ways that are covered in the report, as well as a couple of other innovative ways. Let me just share with you my own personal experience of the importance of the home visiting program, particularly in areas where there are language problems of large, Hispanic populations.

The home visiting program has been exceedingly effective because that means that someone from the area knocks on the door of an area resident who is pregnant for the first time, and says, "Do you know you are eligible for" and, indeed, helps facilitate and direct the recipient to the agencies, so that she can receive all of the programs that she is eligible for and which will benefit her and her unborn child.

Mr. CRAMER. Thank you very much, Senator Bradley.

Thank you, Madam Chairman.

Chairwoman SCHROEDER. Thank you.

Congressman Machtley?

Mr. MACHTLEY. Thank you very much, Madam Chairwoman, and I have a statement which I would ask unanimous consent to submit.

Chairwoman SCHROEDER. Without objection.

Mr. MACHTLEY. I commend you and, certainly, the National Commission to Prevent Infant Mortality, on their study.

I find it almost unbelievable that a country as wealthy as ours could have 40,000 infant mortality occasions each year, which probably could be prevented if we spent, as you have indicated, a very insignificant amount of money.

We've watched on TV as the Kurdish children were shown, and we have all been almost shocked at the newborn babies, yet in this country there isn't apparently that same shocking attitude to the deaths that are occurring every day.

And I wonder, how do we—did your commission—I haven't had a chance to address this—how do we generate that sort of mental mindset to make the American people aware of how much money we are spending on remedial, academic, and health care needs, and how much personal hurt to the children and their families this lack of expenditure is costing us? How do we do that? Have you thought of that and addressed that?

Senator BRADLEY. Well, I think that one of the ways to begin to focus on it is the cost of failing to address the problem. I find that when I tell people that there are 20 countries that have lower infant mortality rates than the United States, that is shocking to them. It is shocking to them that we immunize two-year-olds at a rate that is worse than El Salvador or Nicaragua, but what they don't perceive is that it ultimately costs them in the long run.

For example, they pay $150,000 to keep a low birthweight baby alive. If you facilitated the mother getting prenatal care, during pregnancy you could achieve a healthy baby, which is the objective, at a fraction of that cost. People begin to understand.

When you talk about the need for remedial help dealing with sicknesses like measles and mumps and things for which there are vaccines, and talk about the cost of that to the community, people begin to understand.

And you can go all the way through the process to, ultimately, the cost of a jail cell being $30,000 a year and a college education being only $6,000. You can make the point time and time again that if you don't make the investment in human beings' health and education, you're going to pay for it as a society in terms of lower economic productivity, anti-social behavior, and much more expensive remedial efforts.

And, so, where you start, if you want investment in health and an educated population, is at the beginning. Where is the beginning? Early in pregnancy. And you make an investment in a healthy pregnancy, in a healthy birth, in early childhood nutrition and early childhood education, so that by the time a child reaches kindergarten, they have a foundation of health and nurtured education.

And I think that if you simply lay out the relative costs here, it makes an impact on people, because everybody knows what they have done with their own children.

[Prepared statement of Hon. Ronald Machtley follows:]

PREPARED STATEMENT OF HON. RONALD K. MACHTLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Thank you Madam Chairwoman and my friend Congressman Wolf. I am honored to have this opportunity to address the Select Committee on Children, Youth, and Families as we examine, and hopefully work toward developing, new strategies in prenatal and infant care. I would also like to commend the National Commission to Prevent Infant Mortality for their study and initiative on this important issue.

As I am sure we can all agree, there is no greater investment that we can make with our dollars than in the health and happiness of our children. While many of us sit in accord on this point, answer me why nearly 10% of babies born in the United States die every year? For a country which spends over 11%, up this past year to over 12%, of its GNP on health care, it is a national disgrace to realize that almost 40,000 American babies will not reach their first birthday this year.

We in Congress have long agreed on the importance of many programs, such as WIC and Maternal and Child Health Block Grants, in helping mothers and infants stay healthy. However, despite a small decrease in the percentage of infant deaths this past year, we have seen no significant decrease in the number of low birthweight babies, babies with fetal alcohol syndrome, and drug-addicted babies. The hardest part to face is that each one of the infant syndromes I have named is 100% preventable and that all the money we have pumped into Medicaid expansion and other programs has not made a difference for the nearly 10,000 low birthweight babies born each year.

I do believe there is a two-fold solution to stop these 100% preventable infant deaths. First, we must educate young women about the dangers of smoking, drinking, and drug abuse upon their unborn children. As many of us see in our own school systems and family planning clinics, advisement about changing these behavioral patterns is given to young mothers-to-be. I am pleased to see that many more schools are taking this initiative to teach young women how to have healthier children.

However, the second part of the solution is most important. We must make the prenatal care delivery system more accessible to mothers-to-be. We need to make our fragmented prenatal care delivery system more "user friendly" for mothers, many of whom are frightened, confused and inexperienced. This is where I applaud the principle of "one stop shopping" and my colleague Congressman Bliley for his legislative initiative for maternal and child health services based on this principle. By putting family planning, prenatal and infant care, and nutritional services all under one roof, young mothers will be able to get prenatal check-ups, receive WIC coupons, and have postpartum care more easily.

If mothers could receive regular health care examinations and nutritional advice, we could ease the huge hospital costs surrounding neo-natal care and stop infant deaths due to poor prenatal care. I believe that by making the system more simple for mothers to use, especially adolescents, we could eliminate 25% of infant deaths which occur each year because mothers did not have vital prenatal care.

While our commitment to preventing infant mortality is unwavering, I believe we can make all the money we put into the system work better for mothers and children. First, by working to change the behavioral pattens of mothers by teaching them that drug use, drinking, and smoking can severely harm their child. Secondly, by integrating the various prenatal care services mothers have available to them through one stop shopping. By developing new patterns of behavior and prenatal care delivery, I believe that we can make our investment work even harder for our children.

Again, I thank the committee for letting me speak on this vital issue.

Mr. MACHTLEY. Thank you very much.

Chairwoman SCHROEDER. Thank you very much.

Congressman Peterson?

Mr. PETERSON. Thank you, Madam Chairman.

I also applaud you for allowing me to be on this committee. I have a great interest in this, having worked with juvenile offenders for a number of years, and went through this discovery, that a number of my juvenile offenders—a large number, I might add—were already parents, which was frightening in itself, but then

when I started to look back into the family histories, that many of them never worked toward any kind of prenatal care or what have you, and ended up having some of these very expensive babies that you're talking about. Senator, and I really am interested in this project.

One of the things that I'm concerned with, though, is the bureaucratic obstacles that we're facing in executing what you're suggesting. To deliver the one-stop system, it seems to me, we're going to have to have some kind of central leadership to bring all of those agencies together, to make it happen.

Are you, I should say, hopeful, or have you worked that out, or is there some plan to give us some leadership to bring all of those agencies together to the delivery of these systems?

Senator BRADLEY. The commission's report did not lay out and answer because different people in different circumstances required different answers. Now, it would help if the President of the United States basically shook the bureaucracies, made an investment in computers, looked at the regulations that prevent the sharing of information. That would help.

But my first approach is not to resort to the stick. I've done a couple of editorial boards, along with a variety of other efforts, and usually a reporter asks,"Well, but how are you going to force those big, bad bureaucracies to do what you want them to do? You need a stick". Maybe we do need a stick, but right now we want to say if the "carrot" of information can't move people to do what they should do, maybe we'll use a stick, because the answer is to get services to the people who need them. If the people in need don't get the range of services that are available to them, how are they ever going to break dependency? Or how are they ever going to assure that their kids have a healthy chance? The answer is, they are not.

So, I'm prepared to use the stick, but we're kind of taking a more moderate approach now, in hopes that we might get a presidential endorsement of one-stop shopping, and investment in computers, and sharing of information, and a variety of other things.

I might also mention, there was a point earlier made about all of these poor kids—and I imagine most of the members of the subcommittee have been to the hospital intensive care rooms and have seen them—add to that the complication of drugs, where you get cocaine-addicted babies that are addicted through the umbilical cord of the mother. At a minimum, what we ought to consider is Medicaid coverage for residential drug treatment for pregnant women. At a minimum, we ought to do that.

Mr. PETERSON. Well, I commend you for the work you're doing, and I would offer my assistance. Obviously, we're kind of in the choir here, in this process, because we all recognize what the problems are, it's just a matter of execution, which is the thing that I'm most concerned with. But I certainly commend you for the work you've done with this commission, and those that helped you in that process.

Senator BRADLEY. Thank you.

Chairwoman SCHROEDER. Congressman Wolf just told me that Congressman Bliley has another appointment at 11:00. Is there

anyone else who has some questions that they would like to ask before we—Congressman Klūg?

Mr. KLUG. Again, I want to thank you for holding the hearings, and I will submit a copy of my statement for the record.

Chairwoman SCHROEDER. Without objection.

[Prepared statement of Hon. Scott Klug follows:]

PREPARED STATEMENT OF HON. SCOTT KLUG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mrs. Chairwoman, I want to thank you for holding this important hearing which will examine ways in preventing infant mortality in this country. Infant mortality is the tragic result of not necessarily an underfunding of programs, but rather a lack of prenatal and preventative care that occurs for a variety of reasons.

In rural areas especially, we need an effective, integrated rural health care system that features primary care providers that can provide comprehensive prenatal and pediatric care. This comprehensive care should be backed by an effective referral system. Money should be shifted from large capital expenditures to programs that can include more people in preventative care programs located in "underserved" areas. For example, time and time again rural providers have told me that expensive diagnostic and treatment equipment can be moved from health care center to health care center thereby avoiding large capital outlays. This pooling of resources will allow resources to be freed-up to help solve the devastating problem of infant mortality at its source—lack of basic preventative and educational services.

Attracting physicians to areas that are in need, especially rural areas, is another problem we face. The rate of infant and low birth weight is higher in rural areas and rural women are less likely to receive early prenatal care than in urban areas. Problems from low reimbursements from Medicare and Medicaid, to lack of colleagues in the same field make it difficult to attract doctors. Student loan deferments and other incentives are needed to counter a dwindling number of physicians helping underserved areas.

Integrated care combined with reductions in paperwork are keys in attracting more physicians to shortage areas, and encouraging more patients to get care. Soaring malpractice awards and average malpractice insurance premiums over $38,000 per year have driven doctors out of basic fields of medicine like gynecology and obstetrics. That is an issue that also needs to be addressed.

I want to thank Congressman Bliley for leading the way these past several years in fighting for common sense answers to this country's problem of infant mortality and low birth weight. He has articulated what many experts have realized for years—you can't spend your way out of every problem, or bury it in a myriad of new programs. Integration of services, a change in attitudes and a more efficient care system aimed at prevention are basic changes that must be made. Thank you Mrs. Chairwoman.

Mr. KLUG. Senator, most of what we've heard today, and I think the thrust of at least the anecdotal comments you've pointed out, have been about problems in the urban areas. As we all know, there is a real problem in attracting physicians to rural counties, which is where the highest incidence of low birthweight tends to occur, and where women are least likely to receive early prenatal care.

New Jersey, obviously, like the State of Wisconsin, has rural communities, although many people don't think of New Jersey in quite the same context. How would one-stop shopping help in rural communities?

Senator BRADLEY. A computer doesn't know geographic boundaries. If your computer is sharing information, it's sharing whoever is the eligible person. And I think that there are also some areas where home visiting can have innovative applications.

I mean, I've been in the delta of Mississippi, for example, which is not exactly an urban area, where low birthweight is rampant.

One-stop shopping has the same impact there because what you are able to tell a person, "You're eligible for the following five programs and, if you talk to me, the case manager, I will make sure you get enrolled and receive all of those programs"; the same impact, a different delivery system. It only illustrates the point that there can't be one type of delivery system. You have to have a different type of delivery system, of one-stop shopping, for rural as opposed to urban. My guess is that differences between rural communities will probably require different strategies in the context of one-stop shopping.

Mr. KLUG. Thank you.

Chairwoman SCHROEDER. Congresswoman Collins?

Ms. COLLINS. Thank you, Madam Chair, and I, too, am very pleased to be on this committee.

Senator Bradley, I commend you and Congressman Rowland and the commission, for the fine work that you've done.

These innovative pieces of legislation that you are going to introduce, I think, will really help. You probably already know that my district, the 13th District of Michigan, had the highest infant mortality rate in the nation, and Washington, D.C., unfortunately, is now in first place, we are in second place, and higher than many Third World countries.

And I will be very pleased to take back to my district the news of the legislation that you are going to introduce.

I'm sort of like the news media telling you that you're going to need the big stick. In the State of Michigan, we've had so many layoffs of the social service workers, who are already drastically overburdened, and I really don't know how we are going to be able to implement one-stop, without a lot of help from the Federal Government, in paying for the service workers, to implement the program.

And there's one other need that you spoke of. You spoke of the drug-addicted babies who are born. I've seen those babies in the hospital—very pitiful—but also the fact that some of the addicted mothers abandon those babies and don't come back to the hospitals, and the hospital social service people have to search for the mothers to get them to come back, and it almost makes me wonder if we're going to go back to the children's orphanages that we used to have at the turn of the century, because I wonder what happens to those babies now?

Did your commission look into that at all—those drug-addicted babies who do live, but are abandoned?

Senator BRADLEY. No, we did not look into that specifically. I must say that I'm struck at the same time we hear stories of babies being dropped at emergency rooms, we also hear of grandmothers being dumped at emergency rooms, where families who are under stress caring for an elderly relative, can't take it anymore and take grandmother to the emergency room and just leave her. That is the same kind of problem as babies, at the other end.

I think it's a profound social threat, and it relates to individual responsibility, and it relates to governmental apparatus that should be nurturing and less bureaucratic.

And if there is one theme here, it is get the bureaucracy streamlined and out from between the person who needs the aid and the

money. We have to begin to face up to the fact that maybe we'd do with fewer people but better computers. Maybe we have to do with eliminating the old way of doing things in a bureaucracy, and getting an investment in something like home visiting, to deal with the specific problem. If you connect home visiting with a computer, you've got a different kind of environment than if you have the old bureaucracy with this paper passed to that person, and that paper passed to that telephone number and that telephone number.

So, what we need is a fresh view of how the bureaucracy should function, if we're serious about delivering services to people who need those services, and who are now not getting them either because the bureaucracy made a mistake, or the bureaucracy fouled up, or because we as public officials have been insensitive to the need for more resources, and focus on the life of the recipient and how to break that cycle of dependency.

Ms. COLLINS. One last question, Madam Chair. Saying that your legislation will pass, how long would it take to implement that one-stop? Would it be demonstration projects, or would you just do it across-the-board?

Senator BRADLEY. All four pieces?

Ms. COLLINS. I'm speaking of the one-stop.

Senator BRADLEY. Oh, if the one-stop shopping strategy were applied to existing programs. I would think you would be able to definitely get results within two years.

We also have to begin to look at addressing this question of resources. I mean at present, there are inadequate resources. The idea that maybe we can facilitate Social Security recipients designating a portion of their check for Head Start or WIC or Child and Maternal health, addresses the question of resources. Maybe what we're going to get is not much response. However I bet what we're going to find is a pretty big response. Frankly, I would like to see in every congressional district, an honor roll of those retired persons who have contributed, so that they get some recognition as well as some chance for involvement.

Ms. COLLINS. Thank you.

Thank you, Madam Chair.

Chairwoman SCHROEDER. Thank you. Does anyone else have any questions?

Mr. WALSH. Thank you, Madam Chairwoman, and if I could submit some questions for the record, I'll save some time.

PREPARED STATEMENT OF HON. JAMES T. WALSH A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Madam Chair, thank you for holding this hearing today. I think it is important to say that the increasing rate of infant mortality is disturbing to us all. We all agree that something must be done. The task before us is to determine the best route or method and take action.

The need for a consolidated system to provide prenatal and basic care to young women and their children is crucial. In my district of New York we are already exploring a model program of one-stop-shopping. Most of the funds are contributed by state and local government. Studies show that while Onondaga County's infant mortality rate of 10.5 deaths per 1,000 births is above the national average, the city of Syracuse rate is 15.2 deaths per 1,000 births. In addition to those figures, Syracuse's minority rate of 27.4 deaths per 1,000 births is higher than that of such major metropolitan centers as New York, Chicago and Detroit.

I say all of this—to say—the time is now for federal dollars to assist state and local government in providing accessible services to these young women. In closing I want to say that I support the Bliley bill and I hope that we can move this legislation right along.

Chairwoman SCHROEDER. Thank you.

Thank you so much, Senator, we really appreciate it, and I think just trying to get uniform eligibility would be a phenomenal breakthrough. So, we wish you all the best. We thank you for your innovative ideas, and we appreciate your kicking off this hearing while releasing the commission's report. Thank you.

Senator BRADLEY. Well, thank you, and I think Dr. Rowland should be complimented for his good work on the commission, it was great to work with him. And I know of your strong interest in the committees and, hopefully, some of these things that have been recommended here will actually become law because of the efforts of people on this subcommittee. That's my hope and expectation, that's why I came here this morning. Thank you.

Chairwoman SCHROEDER. Thank you. Well, you certainly did a good job. Thank you very, very much.

Our next witness this morning is no stranger to this committee, in fact, he was the ranking member until this year. So, we're very honored to have Congressman Tom Bliley—Jr., who is the very distinguished Member from Virginia.

We will put your statement in the record, and the floor is yours. I think you know everybody here very well, it's like family. As I say, you just feel like you're on the wrong side of the table, but welcome, we're happy to have you.

STATEMENT OF HON. THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. BLILEY. Thank you, Madam Chairman and members of the committee, it's a pleasure to return. It's a little unusual to be sitting down here, but I thank you for granting me this opportunity to testify this morning, and I, with your permission, will submit my full statement for the record, and try to summarize very quickly.

I thoroughly enjoyed, Dr. Rowland, reading the report of the National Commission to Prevent Infant Mortality last night, and I hope that it will be a clear signal to Congress that it is time to stop defending the status quo, and it's time to end our commitment to an organizational management and control strategy that wastes resources, creates new barriers to services, and which is designed to solve a specific problem rather than to serve a person. And we heard from the Senator the stories of people for whom these programs are designed—poor people, many of whom have severe transportation problems—getting shunted around, and they get frustrated or they just can't get there, and they fall through the cracks.

It was with that in mind that yesterday I introduced H.R. 1968, which is legislation to help address this problem, and I will summarize that briefly now.

It is based on the concept that prenatal care is the nucleus around which all other maternal health services should be provided. As we have heard earlier today, nearly 40,000 babies born in

our country this year, will not survive to see their first birthday. Therefore, I hope that my proposed legislation, the Consolidated Maternal and Health Services Act, will address this problem.

Up to 25 percent of these deaths are now due to low birthweight, which should be 100-percent preventable with adequate prenatal care and proper nutrition.

In reading the report last night, it was very dramatically brought home to me that it costs $15-40,000 for each low birthweight baby that is delivered at a hospital, for the care.

If, through this one-stop, we could shorten that by one day, it would more than pay for any prenatal services the mother might have received.

We've tried to address the problems. We've spent more money on nutrition programs. We have expanded Medicaid eligibility. We are funding new special initiatives before we even have time to evaluate whether prior initiatives are working. Yet, the substantial investment in maternal and child health care has resulted in an outdated, fragmented system, which drives out the very women it is supposed to serve.

A creative approach to harness the combined power of the $11.6 billion that the Federal Government spends to improve health care of mothers and children would eliminate barriers to comprehensive care. Women will have immediate access to all services, from preventive services under prior pregnancy to postpartum care, all offered from a single provider.

The first step to making the programs kinder and gentler is by making them easier to use. Delays in obtaining prenatal care will be eliminated. Children will receive immunizations, health care examinations, preventive lab testing, and nutritional services, all in one place. Prevention will take its rightful place to reduce long-term disabilities.

In response to the shortcomings of the existing system, the legislation provides that, one, the Federal Government would provide more than $7 billion to support the block grant to be placed through to the states, by combining the resources of ten existing programs, including WIC, parts of Medicaid, the Maternal and Child Health Block Grant, and the Title X program. States would determine the eligibility. No state would receive less federal support than it received and spent in the prior fiscal year. However, each state would be required to maintain its existing funding levels to qualify for federal support.

Individuals would receive the full array of medical and nutritional services from a single provider. Participating providers must agree to deliver all services in an integrating system. Administrative savings would be passed on to the states. Qualified providers would be determined by the states. They may include private physicians, state and local health departments, HMOs, not-for-profit clinics, and hospitals.

And with that, I will close and urge each of you to read it and, hopefully, join me as a co-sponsor, and maybe we can get it moving along.

If you have a question or two, I'll try to answer them.

[Opening statement of Hon. Thomas J. Bliley, Jr. follows:]

OPENING STATEMENT OF HON. THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

It is a great pleasure to return to the Select Committee on Children, Youth, and Families. Over the years, the Select Committee has played a special and influential role in bringing vital issues to the forefront of public policy debates. It is an honor to join you again today to examine new strategies for improving the lives and health of our children.

This year's report of the National Commission to Prevent Infant Mortality, I hope, will be a clear signal to the Congress that it is time to stop defending the status quo. It is time to end our commitment to an organizational management and control strategy which wastes resources, creates new barriers to services, and which is designed to solve a specific problem rather than serve a person.

The Commission's report provides excellent examples of how the service delivery system, as presently organized, makes client participation more difficult. I will not use the Committee's time to repeat those illustrations now. The Commission has outlined the problem and the principal approach to the solution. That is, we must integrate the various services so that a client can receive all necessary health services in a single setting.

That recommendation is the basis for the maternal and child health services act which I will introduce this week. There will no doubt be a variety of "one stop shopping" proposals. But prenatal care is the nucleus around which all other maternal health services should be provided.

Two weeks ago, Secretary Sullivan's message to the nation was that infant mortality is a social problem as much as it is a medical problem. His good news that the infant mortality rate may have dropped to 9.1 in 1990 is, however, tempered by a number of caveats. First, this is provisional data. Important data which are necessary for thorough evaluation are not available. It is unclear whether the number of infant deaths have actually decreased or whether the increase in births has accounted for the reduction in the rate. Second, about half of the reduction may be due to improvements in newborn therapy rather than reductions due to preventive health care measures. Finally, we should not forget that approximately 10,000 deaths are due to low birthweights which should be 100 percent preventable. There has been virtually no progress in reducing the incidence of low birthweights. There are still more than one quarter of a million low birthweight births every year. In short, there is still much work to be done.

With Secretary Sullivan's news on infant mortality and the release of the National Commission's report, today's message is that the time for bold action is here. The Congress and the President have put more money into nutrition programs. We have expanded Medicaid eligibility so quickly that state budgets cannot keep pace. We are funding new special initiatives before we even have time to evaluate whether prior initiatives work. But despite these improvements, there is still widespread disappointment among health care professionals and policy makers alike, that the substantial investment in maternal and child health care has not resulted in health outcomes that we should expect and demand.

The policy debate before us is not about our national will to commit resources. Nor does the debate diminish Secretary Sullivan's message of personal responsibility. Rather, it is about a misplaced allegiance to an out-dated, fragmented system which drives out the very people it is supposed to serve.

How do you initially get women into prenatal care?

By providing family planning services and prenatal care in the same facility. This is a critical link especially for adolescence. For example, only 54 percent of pregnant teens begin their prenatal care in the first 3 months of pregnancy.

How do you ensure that a pregnant woman receives vital nutritional services?

By giving commodities or coupons to her each time as she attends her prenatal care. We also need to provide more flexibility to local providers to enhance services and create new incentives for women to use both prenatal care and nutritional services. This is especially important to reach the immigrant population served. For example, many Hispanic and Asian women in the Washington, DC area may not be fully participating in WIC because rice is not an approved food.

How do you manage a high risk pregnancy?

By making a provider responsible for the entire continuum of care before, during, and after a woman's pregnancy.

Each prenatal visit is money in the bank. When you consider that it costs between $14,000 and $30,000 for hospitalization of a low birthweight infant, if a low weight birth stay in the neonatal ward is reduced by just a single day, the entire

cost of prenatal care can be recouped. We do not need any more studies to tell us that basic preventive services are cost effective.

With the release of the Commission report, there is no longer a need to debate whether these services should be provided in a integated setting. But rather, we should immediately examine how and when it is to be done.

The solution I offer, the Consolidated Maternal and Child Health Services Act, is a creative approach to harness the combined power of more than $11.6 billion to improve the health care of mothers and children. This proposal recognizes that the incremental approach to health care management for pregnant women is a barrier, not a gateway, to further reduction in infant mortality and other poor health outcomes.

This concept will eliminate barriers to comprehensive care by giving a woman immediate access to all services, from preventive services prior to pregnancy, to prenatal care including nutrition services during pregnancy, to postpartum care, all from a single provider. Delays in obtaining prenatal care will be eliminated. Children will receive immunizations, health care examinations, preventive laboratory testing, and nutritional services all in one place. Prevention will take its rightful place to reduce long-term disabilities. In response to the shortcomings of the existing system, my legislation provides that:

The federal government will provide more than $7.9 billion to support the block grant by combining the resources of 10 existing programs, including WIC, parts of Medicaid, the Maternal and Child Health Block Grant, and the Title X program.

States would determine eligibility. Savings generated through administrative efficiencies and reduction of long term health care expenses will enable states to expand eligibility.

No state will receive less federal support than it received and spent in the prior fiscal year. However, they would be required to maintain their existing funding levels totaling more than $3.7 billion to qualify for federal support. The block grant will be indexed for inflation, not to exceed 5 percent per year, to provide a stable funding base while controlling the rate of growth.

Individuals will receive the full array of medical and nutritional services from a single provider. Participating providers must agree to deliver all services in an integrated setting.

States will be offered incentives to combine federal support with their state maternal and child programs in order to achieve maximum administrative savings. Federal administrative savings will be passed on to the states.

Qualified providers are determined by the states. They may include private physicians, state and local health departments, HMOs, not-for-profit clinics, and hospitals.

The current levels of funding from ten programs will be combined into a single block grant and will be passed through to the states. In addition, this proposal will enhance the states' ability to coordinate another $100 million in funding generated by local governments and program income. Further reductions in unnecessary administrative costs can be achieved by integrating preventive health care services with comprehensive pregnancy care.

While I know that many "one-stop-shopping" advocates are anxious to combine as many social services as possible with the medical services, we must be careful not to overload providers with responsibilities beyond their capability. We do not want to create mega-agencies as the sole providers. Such an approach will ultimately restrict the number of available providers, and thus, restrict access to care. Flexibility is important to success. While I can foresee that a substance abuse treatment facility could offer comprehensive maternal health services to the clients, not all materal health providers can integrate substance abuse treatment into their facilities. We should encourage innovation without stifling the patient's range of choices beyond the requirement that certain core services must be provided on site.

Let me point out how the Consolidated Maternal and Child Health Act can overcome some of the other less visible barriers which are parts of the infant mortality problem.

Over the years, the experts have told us that one problem, especially in rural communities, is that access to care is limited. My proposal addresses this problem by allowing more providers to participate in maternal and child health programs. Whether you are a metropolitan hospital or a couple health clinic or a private physician, you can participate. A greater number of providers will translate into greater access for clients. With greater physician participation, the entire workload will spread more evenly throughout a community.

And I believe that more private physicians will begin to serve low income clients. Two major reasons private physicians give for not participating in Medicaid are too

much paperwork and noncompliance among patients. My proposal will substantially reduce the administrative burden on the physician. And I believe that the integrated care concept will result in greater compliance among clients. Better compliance will mean lower risk pregnancy. Since the provider will become responsible for the individual's health care before pregnancy and after pregnancy also, the physician will be aware of other medical conditions which must be managed during pregnancy. At the same time, this closer relationship between the physician and the patient will in itself be an incentive for a woman to seek appropriate care.

Although I have focused my remarks this morning on the maternal health side, let me also say that these same concepts will be applied to the child's preventive health concerns.

There will no doubt be skepticism about the block grant approach. But there is an increasing awareness of the success of state administration through block grants. The experience of the 1080s has unquestionably helped to change attitudes toward state administrative capabilities. As Alice Rivlin, former director of the Congressional Budget Office, has written:

"Most of the public investment we need should be made by the states anyway. The real problem is to give the states clearer responsibility and more resources."

We need to stop treating states as "laboratories" and begin respecting them as the sovereign units of government they are meant to be.

Unless we abandon the familiar, incremental approach which protects the status quo, we will inevitably repeat the same mistakes of the past and we will not realize the full potential of reform. To be more specific, simply expanding Medicaid eligibility will not solve the infant mortality problem. Extending eligibility into higher income families will not help those who are at the greatest risk. To assist the most vulnerable population, we must fundamentally change the fragmented system which prevents so many families from obtaining the care they need.

Over the past twenty-five years, we have been committed to a management strategy which has itself become a barrier to good health care. There are no great mysteries of medical technology waiting to be unlocked before we can solve the national tragedy of infant mortality.

A consolidated delivery system offers great potential for breaking the welfare cycle, holding the line on skyrocketing health care costs, and for returning to the traditional federalist roles in which the Federal government provides the capital for states to manage as full-fledged partners. The first step to making government programs "kinder and gentler" is by making them easier to use.

I urge my colleagues to consider the new hope that the Consolidated Maternal and Child Health Services Act offers.

Chairwoman SCHROEDER. Thank you. I really appreciate your being here, and it sounds like we're kind of on the same wavelength, so that's a positive part.

Let me ask you one thing that troubles me about you bill, and that is about Title X. I understand why people get nervous about family planning for people who have not become pregnant but, after they have become pregnant, I would be very worried that by cancelling Title X, many states may not offer the family planning services to the woman. I would think that it would be very important to make sure that the woman has the right to those services after she has had a child, because part of making sure we don't have low birthweight babies and other poor health outcomes, becomes the timing of babies and so forth and so on. That really did concern me, to see that flexibility on Title X that was put in there.

Mr. BLILEY. Well, the only thing that I wanted to see that the bill didn't get caught up as violation of the Hyde language, which is the current law, so I didn't want to get afoul of that. Aside from that, I have no problem whatever.

Chairwoman SCHROEDER. So, you could take Title X with the Hyde language?

Mr. BLILEY. Sure.

Chairwoman SCHROEDER. I mean, we're talking about family planning, we're not talking about——

Mr. BLILEY. Yes.

Chairwoman SCHROEDER. So, there would be no problem if we made sure that Title X held in there for family planning services.

Mr. BLILEY. Right, as long as the Hyde amendment is respected.

Chairwoman SCHROEDER. And the other thing is we're having so much trouble getting private health care providers to serve Medicaid-eligible people in the population. Do you think your proposal would help in that, or hurt?

Mr. BLILEY. I don't think it could hurt. I think what we really need to do, and it would be very difficult to do, is we need to figure some way to reduce the insurance cost or the liability risk for treating them.

One of the reasons that has been explained to me by practitioners in my own state is that because these people don't get the adequate prenatal care and whatnot, they are reluctant to treat them because then something may happen and they get sued, and that's a tragedy, but having served on the Commerce Committee and having gone through trying to reform product liability where we argued over every semicolon, comma, hyphen, as Roy will tell you, for a month, and I don't think we moved at all, although the other side thinks we went off the cliff. It will be very difficult.

Chairwoman SCHROEDER. I know it's hard, although it seems like Medicaid patients usually are the least likely to sue. The other thing that I'm concerned about—you say states will control the eligibility of the people, so they can set whatever standards, right?

Mr. BLILEY. The states control eligibility for Medicaid now.

Chairwoman SCHROEDER. Now, if the states lock in the prior amount of money, like you say, which I think is a good idea, so they don't cut back on that and pick up the block grant, but what if they lock that in, could they then raise the eligibility afterwards, to make the money?

Mr. BLILEY. I would think that we would have to make sure that that didn't happen.

Chairwoman SCHROEDER. So they didn't play games with them?

Mr. BLILEY. That's right. I mean, our goal is to get the services to the people.

Chairwoman SCHROEDER. Absolutely.

Mr. BLILEY. And whatever it takes to do that, that's what we're going to have to—within the Constitution and the law—but I mean, that's basically what we need to do. And I think this legislation is a good start.

Obviously, like any piece of legislation, it is far from perfect, but with the help of everybody on this committee and other members in the House and the committees of jurisdiction, maybe we can get it through.

Chairwoman SCHROEDER. Well, we're all on the same track, I think. It's just working out all the details and, hopefully, we can finally do it.

You have to be out of here by 11:00, is that right?

Mr. BLILEY. Well, everything runs late around here, so if I'm late to the next one—but I appreciate my colleague, and I appreciate

your indulgence for bringing me on quickly, but I'll be happy to yield to a question.

Chairwoman SCHROEDER. We get thrilled by the interest—I mean, the interest level here has been wonderful, and that's very good. So, that's one of the things that kind of ties us down.

Congressman Bilirakis, do you have any questions?

Mr. BILIRAKIS. Thank you, Madam Chairman.

Tom, you were in the audience when Senator Bradley testified and, in talking about a stick that works, he gave me the impression, that we ought to first try an easier approach. Hopefully, the Administration could be convinced to get involved and to basically force the bureaucracies to work.

I tend to favor your approach. That is time that could be wasted just basically trying to use the more diplomacy type of route will result in a lot of deaths, a lot of infant mortality, a lot of problems, a lot of money being spent and needless waste, in terms of infant deaths. I would tend to agree that a stick is needed basically now and the legislation will have to be worked and reworked in certain areas.

Do you feel that your legislation is the stick that is needed to put this into effect and make it work, starting early?

Mr. BLILEY. Well, I hope. I think I would like, all things being equal, to see it happen the way that the Senator testified, but I don't see it happening that way, particularly when you have tightened financial situations, particularly for the states, also for the Federal Government. Agencies of and in themselves are concerned about their budget, their people, and they get caught up in that.

We need to, as a Congress, to say, "Wait a minute, we're not interested in agencies, we're interested in people," and in order to do the people—we're not getting them now with all of this alphabet soup that we have in providing services—we want to do it this way so that we see how it works, and then try it. Maybe I'm wrong, maybe it won't work, but I think what's definitely there now in the record is clear, that what we have is not working. So, let's give this a chance.

Mr. BILIRAKIS. Well, it will work, and I commend you.

And Madam Chairman, I hope that this committee can really earmark—certainly one of the major earmarks of this committee might be to work on this legislation and see if we can get it forward. Thank you.

Chairwoman SCHROEDER. Thank you.

Congressman Cramer.

Mr. CRAMER. I have no questions, thank you.

Chairwoman SCHROEDER. Congressman Peterson?

Mr. PETERSON. I'll defer.

Chairwoman SCHROEDER. All right. Okay, Congressman Klug is gone.

Congressman Wolf.

Mr. WOLF. I have a question, Madam Chairman.

Tom, I want to congratulate on your work on this committee and also on this bill, and I'd like to just read it through, but I think I'll go on as a co-sponsor.

One question I wanted to ask you, and I want to send to Senator Bradley, is, how do you deal with the delicate and difficult problem

of individuals who are using drugs, to get them into the system to participate?

Mr. BLILEY. Well, I think that, obviously, you want to get them the help and all you can, but I don't think that we ought to mandate that in this legislation. We ought to leave the flexibility to the states. In some areas, they may decide that they need to do that. In other areas, they may decide that we need to treat drug rehabilitation separately.

I don't think that we can have a one—and that's part of the problem now. I think we cannot have a one-answer system for the entire nation. That's why we need to give it to the states with flexibility, and that's why we need the one-stop shopping for these programs. And if a state wants to include drugs in it, fine. If they decide not to, I don't think we ought to stop all the rest of it just on that one issue.

Mr. WOLF. Well, I agree, I guess. I just looked at the fact sheet the staff put together. It says that cities with high infant mortality rates are also cities very high in internal use of drugs during pregnancy, and I'm not going to single out any particular region of the country to——

Mr. BLILEY. Well, you can single my city out right now. I mean, we've got a severe problem. In fact, I was in the neonatal intensive care unit and actually talked to an expectant mother who was a drug addict, admitted, and had been off for about six weeks. And it really is sad—I mean, she quite frankly said that "when I was on it, nothing else mattered. That was the only thing that mattered to me was drugs—not my kids—nothing. Not my baby I'm carrying, or anything else." It's really scary.

Mr. WOLF. That's why—I saw that article in the paper yesterday, who watched her children—I think one was age six—involved in prostitution, and somehow—and I don't know the answer, and that's why I wanted to ask you and Senator Bradley, how do you factor in the drug abuse problem? I sense that that's got to be combined with this because then I think you get more people to participate in the one-stop effort. Anyway, I appreciate your testimony. Thanks very much.

Chairwoman SCHROEDER. Congressman Rowland.

Mr. ROWLAND. Thank you, Madam Chairman. And I want to thank my good friend, Congressman Bliley, who I have had the opportunity to work with over the years, for his interest in this problem. It is very difficult to stimulate interest in the general public about the problem, because people usually don't react to something unless they are personally and immediately affected by it, and most people in the country are not personally affected by low birthweight and the infant mortality rate that we have. I think that the additional attention that you focus on this, or the attention that's been focused by this committee and the National Commission to Prevent Infant Mortality, which is now in existence for four years, all of these things together are bringing more attention to this problem, and I feel better about that at this point.

We only recently learned that our infant mortality rate is down to 9.2, which is very satisfying, but other nations reduced theirs, too, so we are still around 20, or 21, or 22 in infant mortality.

It is higher in certain population groups, those people in the lower socioeconomic level, particularly blacks in certain areas where it's 18, and I would say that education is an important thing in dealing with this. We've got to get people to understand the problem relative to drugs, getting good prenatal care, sexually transmitted disease—you're right, it's all tied together. And we have to really work to get people to understand how important it is.

I really appreciate what you're doing. Thank you very much.

Chairwoman SCHROEDER. Thank you very much.

Congressman Walsh.

Mr. WALSH. Thank you, Madam Chairwoman, and thank you for holding this hearing. It's very important to people in my district in central New York.

We had a hearing, a field hearing, last year. We had a very, very high, almost unexplainably high, problem of infant mortality and low birthweight babies, and it's something we're working very hard on. And we have begun a program of one-stop shopping, done with local and state resources and some federal resources.

Tom, I would like to congratulate you for your pioneer work in this effort. I know you've been involved in it for quite a long time, and I admire what you've accomplished, and look forward to joining you on your bill.

One of the things that we've learned up home is—and you mentioned it—that we really have a lack of obstetricians. There's a problem with tort reform all over the country. New York State has wrestled with it, and it seems that doctors in that field have a lot more problems with suits than some of the others, the surgeons and so forth.

And I don't know if there's anything that your legislation does to affect that, if there is, maybe you could tell me, but that affects another problem, and that is early access to prenatal care, and the lack of people involved in that part of the medical field.

And we have a very good physical plant and professional staff in central New York. It's a hospital center. But one of the problems, obviously, with this—one of the issues with this problem is access to prenatal care. Transportation becomes an issue, just somehow making transportation available to people who need to get in for prenatal care, early access to the system.

Is there anything in the bill that deals with transportation for individuals?

Mr. BLILEY. No. That would be left up to the states and the localities, to work those out. They would get the block grant, and then they would have the resources to use as they feel best suited for the particular area they are located in.

Mr. WALSH. Let me ask you this. Quite a long time ago, I was involved in social services myself. I had a caseload of about 90 mothers with—in those days, it was ADC, today it is AFDC—it's very difficult to be pro-active as a caseworker dealing with that many families, but is there a way to improve the system that we have, the structure that we have now, using those caseworkers to help direct mothers who may have already had bad experiences?

Mr. BLILEY. Well, I think that the mere fact that you have the caseworkers, you have the clinics, the one-stop locations, and the

health workers will presumably be notified as to the services available and, as they are dealing with their clients, that they can say, "You ought to go to this place because that's one place where you get your immunizations for your children, you get your WIC, you get your food stamps, you get your health care, everything in one location".

Mr. WALSH. I got the feeling in Senator Bradley's testimony that one-stop shopping then, a computer terminal or a place to go to get one-stop information, not one-stop services, and the concept that we're using in central New York is where you go for all those services, not to go for the information.

Mr. BLILEY. No, this would be for the services, not for the information. You get the services right there in one place, that's the whole purpose of it because what we have now is fragmented. The services are there in the community, but they are spread out all over, and the people get frustrated, or for lack of transportation or for other reasons, lack of time, they are unable to partake, for one reason or another.

Mr. WALSH. Just one last point, and that is, in New York State, we're going to have about a $6 billion budget deficit this year. And one of the things that has occurred in the recent past, in the last ten years or so, is an increase in this case management concept, which is akin to social worker work, but it's a duplication, I think, in many cases, of it. And as we become more and more reliant on case management and as state resources diminish, we want to make sure we don't create a system that's reliant on more case management. I think whatever we do should be more involved with getting the services directly to the people at a one-stop supermarket of services. Thank you.

Chairwoman SCHROEDER. Thank you very much.

I think what Senator Bradley was saying, if I remember right, he'd like to have the services in one place, but I think the computer was in answer to the rural areas. I mean, he was saying in response to how it worked——

Mr. BLILEY. He was saying—I think so—that the information would be available. The computer doesn't respect boundary lines.

Chairwoman SCHROEDER. Absolutely, and I think he meant it might not be totally feasible in some rural areas.

Congressman Skaggs, no questions?

Congressman Miller, it's interesting to see you at this end of the table. Welcome.

Mr. MILLER. Thank you.

Chairwoman SCHROEDER. It's a very strange morning, with Bliley on the wrong side, you at the wrong end.

Mr. MILLER. Well, things move on.

Mr. BLILEY. That's right.

Mr. MILLER. Thank you. Tom, let me commend you for this effort because I think you raise some very fundamental questions about the delivery of these services to children and families.

I was just going through this in our local area and realized how many people we had asking the same people their name, their address, their phone number, their Social Security number, and the number of children in their families, each and every time they moved for a different program, so I hope that we would not lose

sight of this. The one-stop shopping delivery of services should be made convenient and accessible, but also the number of times we force people to jump the same hurdle should be minimized along with the cost of doing that.

But let me ask you on the block grant, if you could explain what happens to the entitlement nature of Medicaid under the block grant in terms of services and people's entitlement to some of those services.

Mr. BLILEY. In order to participate, the state would have to agree to provide the services that they are currently providing that are required under the terms of the existing law. And the only thing this would do is would be say, "State, if you participate and we hope you will, you get to participate in the block grant, but you must put them all in one location, under one roof", so that——

Mr. MILLER. But in terms of people's entitlement—that is the word here, to those services, they would still be——

Mr. BLILEY. They would be entitled.

Mr. MILLER [continuing]. We would be transferring that entitlement to the state level. They could administer it, hopefully——

Mr. BLILEY. On the Medicaid, it's my understanding the states administer it anyway and, of course, participate. But, no, we wouldn't affect their entitlement to the service. By all means, the whole purpose of the thing is to see they get the service.

Chairwoman SCHROEDER. And it wouldn't change under Gramm-Rudman—changing it to a block grant wouldn't change it, would it?

Mr. BLILEY. I don't see how it would. It might affect the dollar levels, but I don't see it affecting the services.

Mr. MILLER. Currently, a couple are exempt.

Mr. BLILEY. Some of these programs already in the so-called safety net are exempted from Gramm-Rudman.

Chairwoman SCHROEDER. And by moving them into the block grant, are you removing them from the exemption, I guess is my question.

Mr. BLILEY. It's not my understanding, and I——

Chairwoman SCHROEDER. You would fight that, obviously.

Mr. BLILEY. I appreciate you raising that point, and we would certainly want to make sure that we didn't jeopardize that.

Chairwoman SCHROEDER. Absolutely.

Well, I thank you very much for your patience with the committee. See, we're just so interested in what you have to say, we could keep you here all day.

Mr. BLILEY. I would say that under yours and Frank's reign, you are much better at keeping the members, unfortunately, than George and I were, Madam Chairman. Thank you very much.

Chairwoman SCHROEDER. We thank you, again, for your help and your participation. Now, we have a very distinguished panel that I'd like to introduce to the committee. First, we have Dr. Robert Harmon, who is the Administrator of Health Resources and Services Administration for Health and Human Services, from Rockville, Maryland.

We have Maria Gomez, the Executive Director of Mary's Center for Maternal and Child Care in Washington, D.C.; Judith Jones,

who is the Associate Clinical Professor and Director, National Center for Children in Poverty, Columbia University School of Public Health, in New York, and we have Kay Johnson, who is the Senior Health Policy Advisor, March of Dimes Birth Defects Foundation, in Washington, D.C.

We certainly appreciate all of you attending this morning. It's very, very helpful to have you here to give us some guidance, and I think we will put all of your statements in the record. Maybe, since you've listened to the two witnesses, you may want to respond to that. If we could have each of you summarize your statements. Let us start with you, Dr. Harmon, and we welcome you, and we'll be interested to hear all the new things that are going on in your area. Welcome.

STATEMENT OF ROBERT HARMON, M.D., M.P.H., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Dr. HARMON. Thank you, Madam Chairwoman. I used to be one of your constituents, Madam Chairwoman, back in the early '70s, when I was a resident at the University of Colorado Medical Center.

Chairwoman SCHROEDER. Well, we're glad to have you here. Come back to Colorado anytime. David and I welcome you.

Dr. HARMON. I do every chance I can.

Chairwoman SCHROEDER. Good.

Dr. HARMON. I am the Administrator of HRSA, which is in the U.S. Public Health Service. Your topic today, Generating Innovative Strategies for Healthy Infants and Children, could not be more important or timely from the point of view of our Department.

Secretary Sullivan is totally committed to achieving real progress in this area. Only last week he announced a major organizational change in our Department, designed to place greater emphasis and focus on the needs of America's children and families.

This reorganization created a single new operating division called the Administration for Children and Families, which includes the major components of the Department whose programs are aimed at improving the health and well being of children.

I would like to focus most of my remarks this morning on another Administration initiative called Healthy Start. As Dr. Sullivan has stated many times, it is unthinkable that the U.S., a nation of enormous wealth and resources, should continue to be worse than 20th among the world's developed nations in infant mortality. So, the Healthy Start initiative is directed at precisely this difficult problem.

It is a demonstration project with a goal to reduce the rate of infant mortality by 50 percent in ten selected urban and rural communities over a five-year period. To give you a better idea of exactly how we envision this initiative succeeding, let me address some key ingredients.

First, is innovation. Our current practices have failed to adequately reduce infant mortality, although it is coming down gradually. Therefore, it is essential that we find new and creative ap-

proaches to bringing high-risk women and their infants into care early.

The communities targeted by Healthy Start will be encouraged to consider innovative approaches that can produce substantial improvement. They may wish, for example, to offer prenatal smoking cessation programs for the first time, or launch a major public information campaign.

Next, is community commitment and involvement. Each selected community will be required to demonstrate a true commitment to the 50-percent reduction goal. Clear goals and objectives must be set, and resources will be expected to be contributed by local and state governments, by the private sector, and by schools and other community organizations. Successful applicants may have already lined up, for example, school curriculum time or church volunteers. And, incidentally, a community consortium will be required for the grantees.

The third ingredient is increased access to care. As you will be hearing today, and have already heard from other witnesses, one of the most important factors in preventing low birthweight and infant mortality related to it, is early and continuous care for pregnant women and their infants. Improving access will be an integral part of the project. For example, grantees may seek to open new clinics which offer one-stop shopping under one roof.

The next item is service integration. Medical care-health care alone is not sufficient to achieve the dramatic progress that we need. There must be careful coordination among all providers of services—health, social, and other. Thus, Healthy Start will require a comprehensive package of services responsive to the community's specific needs. Again, such aspects as one-stop shopping, outreach, home visiting, child care, case management, family planning, public education, and a variety of other services can be covered.

The fifth ingredient is personal responsibility. This is perhaps the most important among the essential ingredients in Healthy Start. Individuals and families must ultimately accept responsibility for producing and sustaining a healthy baby. Our program will aid them in doing so through public education and other programs directed towards behavioral causes of infant mortality, such as use and abuse of alcohol and drugs, smoking, poor nutrition, and sexually transmitted diseases.

Madam Chairwoman, we are appreciative of the congressional support for Health Start so far in Fiscal Year 1991. The supplemental appropriation for this year contains $25 million for the first start-up round of Healthy Start grants. In FY92, we are requesting $171 million, or about a sevenfold increase to expand and continue Healthy Start. On April 17th, we published in the Federal Register the Notice of Availability of Funds, alerting interested applicants they have until July 15 of this year, to submit applications for Healthy Start funding. We expect, by the way, at least 50 applications.

We also published on that date a notice of public technical assistance meetings we intend to conduct in the near future, in four U.S. cities. Grants, by the way, will be awarded by August or September.

So, in conclusion, Madam Chairwoman, we in HHS are determined to see a significant improvement in what has seemed to be an almost intractable problem. By concentrating substantial funding, services integration, and innovation in these ten communities, we believe we can achieve a breakthrough in this vitally important area of endeavor.

Thank you for the opportunity to testify, I'll be pleased to address any questions or comments.

Chairwoman SCHROEDER. Thank you.

[Prepared statement of Robert G. Harmon, M.D. follows:]

PREPARED STATEMENT OF ROBERT G. HARMON, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Madam Chairwoman and Members of the Committee:

I am Dr. Robert Harmon, Administrator of the Health Resources and Services Administration (HRSA), an agency of the U.S. Public Health Service (PHS). I am pleased to appear before you today, as you consider the important subject of innovative strategies for improving the health of infants and children.

Introduction

Your topic today could not be more important or more timely from the point of view of our Department. Secretary Louis Sullivan is totally committed to achieving real progress in this area. He recently described the ultimate goal of his efforts to be, "a nation where babies will be more likely to be born healthy, where children will be nurtured, where adolescents will be guided and cared for, and where our young people will be prepared for adulthood by giving them love, discipline, challenge and responsibility."

The New Administration for Children and Families

This is not mere rhetoric, Madam Chairwoman. Only last week, Dr. Sullivan announced a major organizational change in our Department designed to place greater emphasis and greater focus

on the needs of America's children and families. This reorganization created a single new agency, which includes the major operating components of the Department whose activities are aimed at improving the health and well-being of children. This includes programs from the previous Family Support Administration and the Office of Human Development Services, as well as the Maternal and Child Health Block Grant program administered until now by HRSA in the Public Health Service.

This newly created organization, named the Administration for Children and Families, will have a budget of $27 billion and a staff of over 2000 people. The many child and family programs created over the years will be brought together in a single organizational unit in order to enhance our Department's ability to serve children and families.

The Department is now engaged in implementing the reorganization announced by Secretary Sullivan last week and has created a task force to work out the details.

THE HEALTHY START INITIATIVE

I would like to focus most of my remarks this morning on another Administration initiative which was developed by President Bush, Secretary Sullivan, and Assistant Secretary for Health James Mason, and for which I will have the primary administrative responsibility: Healthy Start.

As Dr. Sullivan has stated many times, it is "unthinkable" that the United States, a nation of enormous wealth and resources,

should continue to be worse than 20th among the world's developed nations in infant mortality. The "Healthy Start" initiative is directed at precisely this very difficult problem.

Healthy Start is a demonstration project, whose goal is to reduce the rate of infant mortality by 50 percent in ten selected communities over a five-year period. We propose to do this by concentrating new and existing resources to maximize the effect of our investment of public dollars, capitalize on the initiative of families and neighborhoods, and reward responsible behavior.

To give you a better idea of exactly how we envision this initiative succeeding, let me address the key ingredients as we see them at this point.

1. Innovation.

Current practices have failed to adequately reduce infant mortality. Infant mortality rates, as you know, have leveled off in recent years. (Although we are somewhat encouraged that recently-announced preliminary data for 1990 indicate significant improvement in the overall U.S. infant mortality rate, it is still at an unacceptably high level.) Therefore, it is essential that we find new and creative approaches to bringing high risk women and their infants into care. The communities targeted by Healthy Start will be encouraged to consider innovative approaches that can produce substantial improvement.

2. Community Commitment and Involvement.

Each community selected to participate in Healthy Start will be required to demonstrate a true commitment to a 50% reduction in infant mortality over five years. Clear goals and objectives must be set, and resources will be expected to be contributed by local and State governments, by the private sector, and by schools and other community organizations.

3. Increased Access to Care.

As you will be hearing today from other witnesses, one of the most important factors in preventing low birthweight and the infant mortality related to low birthweight is early and continuous health care for all pregnant women and their infants. Improving access to care, therefore, will be an integral part of all ten Healthy Start projects. Grantees, for example, may seek to open new clinics.

4. Service Integration.

Medical care alone is not sufficient to achieve dramatic progress in the reduction of infant mortality. There must be careful coordination among all providers of services--both medical and social services. Thus, Healthy Start will require a comprehensive package of services responsive to the community's specific needs, including such aspects as: one-stop shopping; outreach; home visiting; child care; case management; family planning; public education; and other social, educational and financial support.

5. Personal Responsibility.

Last, and perhaps most important, among the essential ingredients we envision for the Healthy Start Initiative is personal responsibility. Individuals and families must ultimately accept responsibility for producing and sustaining a healthy baby. They can be aided in doing so through public education and other programs directed towards behavioral causes of infant mortality, such as alcohol, drugs, smoking, poor nutrition, and sexually transmitted diseases. Secretary Sullivan has specifically directed us to address the social value system that leads to negative personal behaviors and irresponsible actions by expectant mothers and fathers--particularly those affecting the increased number of teen pregnancies. Grantees, for example, may seek to bring more addicted pregnant women into treatment.

GETTING STARTED

Madam Chairwoman, we are appreciative of the congressional support for Healthy Start received thus far. On April 10, President Bush signed into law P.L. 102-27, the Fiscal Year 1991 Dire Emergency Supplemental Appropriation bill. That measure contains an appropriation of $25 million for the first "start-up" round of Healthy Start grants. For Fiscal Year 1992, we are requesting an appropriation of $171 million specifically for Healthy Start. This request includes a direct appropriation of $139 million in new money, with the remainder coming from areas already concerned with infant mortality-related issues.

Please keep in mind that the federal government is already spending over $7 billion on infant mortality related programs. This is through Medicaid, the Department of Agriculture's WIC program, the Maternal and Child Health Block Grant, and Public Health Service programs such as Community Health Centers, Migrant Health, and maternal and child health special project grants, to name just a few. We see Healthy Start as providing a unifying theme for encouraging the optimal development of young families.

On April 17, we published in the Federal Register a Notice of Availability of Funds, alerting all interested parties that they have until July 15 of this year to submit applications for Healthy Start funding. We spelled out specific eligibility criteria for the consideration of potential applicant communities. We also published on that date a notice of public meetings we intend to conduct in Los Angeles (April 30), Philadelphia (May 9), Atlanta (May 10), and Chicago (May 13). At these "technical assistance" meetings, detailed implementation plans and program application guidance will be made available and discussed.

In addition to these formal meetings, we intend to involve Central and Regional program officials from HRSA's Maternal and Child Health Bureau and our Bureau of Health Care Delivery and Assistance, from the Health Care Financing Administration, from the new Administration for Children and Families, and from other federal programs such as the Agriculture Department's WIC

program. These officials will be available to meet with representatives of eligible communities and organizations to provide technical assistance to aid in such aspects as needs assessment, site development, and operational planning. State Health Officers, State Medicaid officials, State Maternal and Child Health Directors, State social services directors, State administrators of family support programs, and State WIC officials, many of whom have been actively involved in planning Healthy Start, will be asked to participate in the provision of guidance and technical assistance to eligible communities.

Through all these devices, we hope to secure a large number of high quality competing applications for the ten pilot projects to be funded.

We expect that the applications received by the July 15 deadline will be reviewed carefully over the summer, and that actual grant awards for Fiscal Year 1991 will be made in September.

Finally, I would note that a public information and education campaign is an essential component of the Healthy Start initiative. We intend to launch such an effort, focused at both the local and national levels.

CONCLUSION

Madam Chairwoman, we in DHHS are determined to see a significant improvement in what has seemed to be an almost intractable problem: how to reduce the appalling rate of infant mortality in

the United States of America. By concentrating substantial funding, services integration, and innovation in ten communities, we believe we can achieve a break-through in this vitally important area of endeavor.

We ask that the Congress continue its support for this effort. Working together, I am certain that we can make a positive difference in the lives of our most important national asset: our children.

Thank you again for the opportunity to testify. I will be pleased to answer any questions you may have.

Chairwoman SCHROEDER. Let's go to Maria Gomez next.

STATEMENT OF MARIA GOMEZ, EXECUTIVE DIRECTOR, MARY'S CENTER FOR MATERNAL AND CHILD CARE, WASHINGTON, DC

Ms. GOMEZ. Good morning, Madam Chairman and other members of the committee. My name is Maria Gomez, and I am the Executive Director for Mary's Center for Maternal and Child Care, which is located in the Adams-Morgan area of the District of Columbia.

I am honored to appear before you today to give an overview of the valuable health and social services Mary's Center provides to the Northwest area of the District of Columbia. I will also explain numerous linkages Mary's Center has made with other local organizations in order to improve our services and our clients' access to such services.

Mary's Center is a nonprofit community-based prenatal and pediatric care clinic, which was established to serve the overwhelming demand for bilingual maternal and pediatric services in the Adams-Morgan, Mt. Pleasant, Columbia Heights, and adjacent neighborhoods of Northwest. The clinic was initiated jointly by the D.C. Mayor's Office on Latino Affairs and the D.C. Commission of Public Health, and it has been serving the public since October 3, 1988, with funding from the District of Columbia, the Federal Government, and private foundations.

Mary's Center is committed to providing health services that are accessible, affordable, and culturally acceptable to low-income, uninsured Latino and other women living in the target areas already mentioned. The majority of our clients are newly-arrived undocumented immigrants from war-torn countries of Central America. They have very limited formal education and few job skills. As a result, the majority have no health coverage whatsoever.

Normally, pregnant women within this group might be forced to go without crucial prenatal and pediatric care for their children due to such financial constraints. However, Mary's Center's completely bilingual team of nurse-midwives, registered nurses, social workers, a pediatrician, a medical assistant, a health educator, and a core of volunteers make it possible for these women and children to receive a variety of medical and social services that they would otherwise be ineligible for through such programs as Medicaid and Aid for Families with Dependent Children.

While these young immigrant Hispanic families experience great stress, the majority are physically healthy, display considerable determination and strength of character, and have relatively sophisticated coping skills. Most women within this population do not smoke or drink alcohol when they arrive in this country, and they have nutritious dietary habits. So, in order to capitalize on these existing healthy habits, Mary's Center uses intensive one-to-one counseling and group discussions that combine culturally acceptable and attainable methods to address such issues as prenatal and well-baby care, effective parenting techniques, future planning, and spousal and child abuse.

Mary's Center staff also provides patients with professional advice and referrals for community assistance related to housing,

employment, day care, legal assistance, and educational opportunities. These services are provided to Mary's Center patients during their regularly scheduled visits, at other community-based agencies and schools, and through home visits.

Families served by Mary's Center especially benefit from the clinic's linkages to other community projects and programs. These include the Julian Safran Medical Group and Columbia Hospital for Women provide a medical director to Mary's Center at no charge, accepts all normal deliveries referred by the clinic, and grants delivery privileges to our four nurse-midwives.

Two, Holy Cross Hospital in Maryland accepts five high-risk pregnancies from Mary's Center each month, and provides further prenatal care and full delivery services at a cost to the patient of $450 for the entire care.

Three, free amniocentesis exams are provided by the Wilson Genetic Center at George Washington University Hospital, and sonogram exams are performed by the Safran Group, at no charge, a savings to our patients of $150-200 each.

Four, our clients of Mary's Center can also receive genetic and developmental evaluations of their unborn children and infants, by a physician and genetic counselor from Georgetown University Hospital's Genetic Counseling program.

Five, the D.C. Commission of Public Health provides Mary's Center with free vaccines to immunize close to 3,000 each year, which saves our clients up to $351,000.

Six, the D.C. Bureau of Laboratories performs all necessary tests at no cost to the Center.

Seven, the D.C. Commission of Public Health details one of their clinic pediatricians to the Center to provide primary care to all of our newborns and their siblings up to age six.

Eight, through its close association with another community-based organization, Mary's Center can provide needy clients with a range of services including, but not limited to, day care, services for disabled children, housing, job training and employment, and enrollment in adult education programs.

Nine, also in conjunction with this community-based agency, Mary's Center administers a program that was funded by the Federal Government under the Office of Adolescent Pregnancy programs. It's called "Para Ti", which means "for you." It's a program specially designed to meet the needs of pregnant adolescents.

Ten, through the clinic's sponsorship of the bilingual health access project, Mary's Center clients and all other close by community-based agency clients can receive help in filling out Medicaid applications, in obtaining other public assistance, food coupons, and referrals to other community services.

Eleven, Mary's Center patients can also acquire car seats for their children on-site, provided by the D.C. Department of Public Works, and also just recently, we just got through the D.C. Safe Child Coalition, we can administer during our home visits, a smoke detector to every client in our program.

Other linkages with churches, private physicians and other medical clinics provide Mary's Center clients with HIV testing and long-term counseling, specialty medical care, immediate shelter for

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abused women and children with case management and long-term plans for the families.

Mary's Center's incorporation of nurse-midwives—there's no obstetricians in this clinic, by the way, except for our medical director—and treatment of pregnancy and childbirth as healthy, natural processes reflects the cultural traditions of the predominantly Central American clients we serve. By offering pregnancy testing, prenatal and pediatric health care in one location, Mary's Center has an excellent chance of identifying women early in their pregnancies and monitoring their families through their children's sixth year.

Mary's Center has also very recently been involved in the establishment and management of the Healthy Babies Project in Ward 5 of the District, which is dedicated to improving the health care received by high-risk, low-income, substance-abusing pregnant women and their infants up to one year of age.

On behalf of Mary's Center's staff and its Board of Directors, I would like to thank you for inviting me to speak to you today. I hope that the Federal Government, the District of Columbia, and the private sector will continue to make it possible for clinics like Mary's Center to provide accessible, affordable, and quality health care to low-income and uninsured women and children of our city. Thank you very much.

Chairwoman SCHROEDER. Thank you very much, and we appreciate very much your attendance this morning.

[Prepared statement of Maria S. Gomez follows:]

PREPARED STATEMENT OF MARIA S. GOMEZ, EXECUTIVE DIRECTOR, MARY'S CENTER FOR MATERNAL AND CHILD CARE, INC., WASHINGTON, DC

GOOD MORNING MEMBERS OF THE COMMITTEE.

MY NAME IS MARIA S. GOMEZ AND I A MA THE EXECUTIVE DIRECTOR OF MARY'S CENTER FOR MATERNAL AND CHILD CARE, INC. LOCATED IN THE ADAMS-MORGAN AREA OF THE DISTRICT OF COLUMBIA. I AM HONORED TO APPEAR BEFORE YOU TODAY TO GIVE AN OVERVIEW OF THE VALUABLE HEALTH AND SOCIAL SERVICES MARY'S CENTER PROVIDES TO THE N.W. AREA OF THE DISTRICT OF COLUMBIA. I WILL ALSO EXPLAIN THE NUMEROUS LINKAGES MARY'S CENTER HAS MADE WITH OTHER LOCAL ORGANIZATIONS IN ORDER TO IMPROVE OUR SERVICES AND OUR CLIENTS' ACCESS TO SUCH SERVICES.

MARY'S CENTER IS A NON-PROFIT COMMUNITY-BASED PRENATAL AND PEDIATRIC CARE CLINIC WHICH WAS ESTABLISHED TO SERVE THE OVERWHELMING DEMAND FOR BILINGUAL MATERNAL AND PEDIATRIC SERVICES IN THE ADAMS-MORGAN, MT. PLEASANT, COLUMBIA HEIGHTS AND ADJACENT NEIGHBORHOODS OF N.W. THE CLINIC WAS INITIATED JOINTLY BY THE D.C. MAYOR'S OFFICE ON LATINO AFFAIRS AND THE COMMISSION OF PUBLIC HEALTH AND IT HAS BEEN SERVING THE PUBLIC SINCE OCTOBER 3, 1988 WITH FUNDING FORM THE DISTRICT OF COLUMBIA, THE FEDERAL GOVERNMENT AND PRIVATE FOUNDATIONS.

MARY'S CENTER IS COMMITTED TO PROVIDING HEALTH SERVICES THAT ARE ACCESSIBLE, AFFORDABLE AND CULTURALLY-ACCEPTABLE TO LOW-INCOME, UNINSURED LATINO AND OTHER WOMEN LIVING IN THE TARGET AREAS ALREADY MENTIONED. THE MAJORITY OF OUR CLIENTS ARE NEWLY-ARRIVED UNDOCUMENTED IMMIGRANTS FROM WAR-TORN COUNTRIES OF CENTRAL AMERICA. THEY HAVE VERY LIMITED FORMAL EDUCATIONS AND FEW JOB SKILLS. AS A RESULT, THE MAJORITY HAVE NO HEALTH COVERAGE WHATSOEVER. NORMALLY, PREGNANT WOMEN WITHIN THIS GROUP MIGHT BE FORCED TO GO WITHOUT CRUCIAL PRENATAL AND PEDIATRIC CARE FOR THEIR CHILDREN DUE TO SUCH FINANCIAL CONSTRAINTS. HOWEVER, MARY'S CENTER'S COMPLETELY BILINGUAL TEAM OF NURSE-MIDWIVES, REGISTERED NURSES, SOCIAL WORKERS, A PEDIATRICIAN, A MEDICAL ASSISTANT, A HEALTH EDUCATOR AND A CORE OF VOLUNTEERS MAKE IT POSSIBLE FOR THESE WOMEN AND CHILDREN TO RECEIVE A VARIETY OF MEDICAL AND SOCIAL SERVICES THAT THEY WOULD OTHERWISE BE INELIGIBLE FOR THROUGH SUCH PROGRAMS AS MEDICAID AND AID FOR FAMILIES WITH DEPENDENT CHILDREN.

WHILE THESE YOUNG IMMIGRANT HISPANIC FAMILIES EXPERIENCE GREAT STRESS, THE MAJORITY ARE PHYSICALLY HEALTHY, DISPLAY CONSIDERABLE DETERMINATION AND STRENGTH OF CHARACTER, AND HAVE RELATIVELY SOPHISTICATED COPING SKILLS. MOST WOMEN WITHIN THIS POPULATION DO NOT SMOKE OR DRINK ALCOHOL WHEN THEY ARRIVE IN THIS COUNTRY AND THEY HAVE NUTRITIOUS DIETARY HABITS. TO CAPITALIZE ON THESE EXISTING HEALTHY HABITS, MARY'S CENTER USES INTENSIVE ONE-TO-ONE COUNSELING AND GROUP DISCUSSIONS THAT COMBINE CULTURALLY ACCEPTABLE AN ATTAINABLE METHODS TO ADDRESS SUCH ISSUES AS

PRENATAL AND WELL-BABY CARE, EFFECTIVE PARENTING TECHNIQUES, FUTURE PLANNING AND SPOUSAL AND CHILD ABUSE. MARY'S CENTER STAFF ALSO PROVIDES PATIENTS WITH PROFESSIONAL ADVICE AND REFERRALS FOR COMMUNITY ASSISTANCE RELATED TO HOUSING, EMPLOYMENT, DAY-CARE, LEGAL ASSISTANCE AND EDUCATIONAL OPPORTUNITIES. THESE SERVICES ARE PROVIDED TO MARY'S CENTER PATIENTS DURING THEIR REGULARLY SCHEDULED VISITS, AT OTHER COMMUNITY BASED AGENCIES AND SCHOOLS AND THROUGH HOME VISITS. FAMILIES SERVED BY MARY'S CENTER ESPECIALLY BENEFIT FORM THE CLINIC'S LINKAGES TO OTHER COMMUNITY PROJECTS AN PROGRAMS.

1. THE JULIAN SAFRAN MEDICAL GROUP AND COLUMBIA HOSPITAL FOR WOMEN (CHW) PROVIDE A MEDICAL DIRECTOR TO MARY' CENTER AT NO CHARGE, ACCEPTS ALL NORMAL DELIVERIES REFERRED BY THE CLINIC AND GRANTS DELIVERY PRIVILEGES TO OUR NURSE-MIDWIVES.

2. HOLY CROSS HOSPITAL IN MARYLAND ACCEPTS FIVE HIGH RISK PREGNANCIES FORM MARY'S CENTER EACH MONTH, AND PROVIDES FURTHER PRENATAL CARE AND FULL DELIVERY SERVICES.

3. FREE AMNIOCENTESIS EXAMS ARE PROVIDED BY THE WILSON GENETIC CENTER AT GEORGE WASHINGTON UNIVERSITY HOSPITAL AND SONOGRAM EXAMS ARE PERFORMED BY THE SAFRAN GROUP - A SAVINGS TO OUR CLIENTS OF $150-200.

4. CLIENTS OF MARY'S CENTER CAN ALSO RECEIVE GENETIC AND DEVELOPMENTAL EVALUATIONS OF THEIR UNBORN CHILDREN AND INFANTS BY A PHYSICIAN AND GENETIC COUNSELOR FROM GEORGETOWN UNIVERSITY HOSPITAL'S GENETIC COUNSELING PROGRAM.

5. THE D.C. COMMISSION OF PUBLIC HEALTH PROVIDES MARY'S CENTER WITH FREE VACCINES TO IMMUNIZE 2,925 CHILDREN EACH YEAR WHICH SAVES OUR CLIENTS UP TO $351,000.

6. THE D.C. BUREAU OF LABORATORIES PERFORMS ALL NECESSARY TESTS AT NO COST TO THE CENTER.

7. THE D.C. COMMISSION OF PUBLIC HEALTH DETAILS ONE OF THEIR CLINIC PEDIATRICIANS TO THE CENTER TO PROVIDE PRIMARY CARE TO ALL OUR NEWBORNS AND THEIR SIBLINGS UP TO AGE SIX.

8.. THROUGH ITS CLOSE ASSOCIATION WITH THE FAMILY PLACE, MARY'S CENTER CAN PROVIDE NEEDY CLIENTS WITH A RANGE OF SERVICES

INCLUDING, BUT NOT LIMITED TO, DAY CARE, SERVICES FOR DISABLED CHILDREN, HOUSING, JOB TRAINING, AND EMPLOYMENT, AND ENROLLMENT IN ADULT EDUCATION PROGRAMS.

9. ALSO IN CONJUNCTION WITH STAFF AT THE FAMILY PLACE, MARY'S CENTER ADMINISTERS THE "PARA TI" PROGRAM ESPECIALLY DESIGNED TO MEET THE NEEDS OF PREGNANT ADOLESCENTS.

10 THROUGH THE CLINIC'S SPONSORSHIP OF THE BILINGUAL HEALTH ACCESS PROJECT, MARY'S CENTER CLIENTS AND ALL OTHER CLOSE BY COMMUNITY BASE AGENCY CLIENTS CAN RECEIVE HELP IN FILLING OUT MEDICAID APPLICATIONS, IN OBTAINING OTHER PUBLIC ASSISTANCE, FOOD COUPONS, AND REFERRALS TO OTHER COMMUNITY SERVICES.

11. MARY'S CENTER PATIENTS CAN ALSO ACQUIRE CAR SEATS FOR THEIR CHILDREN ON-SITE, PROVIDED BY THE D.C. DEPARTMENT OF PUBLIC WORKS' PROJECT SAFE CHILD. ALSO THROUGH THE PROJECT SAFE CHILD PROGRAM WE CAN ADMINISTER, DURING OUR HOME VISITS, A FIRE ALARM KIT TO EVERY CLIENT IN THE PROGRAM.

OTHER LINKAGES WITH CHURCHES, PRIVATE PHYSICIANS AND OTHER MEDICAL CLINICS PROVIDE, MARY'S CENTER CLIENTS WITH HIV TESTING AND LONGTERM COUNSELING, SPECIALTY MEDICAL CARE, IMMEDIATE SHELTER FOR ABUSED WOMEN AND CHILDREN WITH CASE-MANAGEMENT AND LONGTERM PLANS FOR THE FAMILIES.

MARY'S CENTER'S INCORPORATION OF NURSE-MIDWIVES AND TREATMENT OF PREGNANCY AND CHILDBIRTH AS HEALTHY, NATURAL PROCESSES REFLECTS THE CULTURAL TRADITIONS OF THE PREDOMINANTLY CENTRAL AMERICAN CLIENTS WE SERVE. BY OFFERING PREGNANCY TESTING, PRENATAL AND PEDIATRIC HEALTH CARE IN ONE LOCATION, MARY'S CENTER HAS AN EXCELLENT CHANCE OF IDENTIFYING WOMEN EARLY IN THEIR PREGNANCIES AND MONITORING THEIR FAMILIES THROUGH THEIR CHILDREN'S FIFTH YEAR.

MARY'S CENTER HAS ALSO VERY RECENTLY BEEN INVOLVED IN THE ESTABLISHMENT AND MANAGEMENT OF THE HEALTHY BABIES PROJECT IN WARD 5 OF THE DISTRICT WHICH IS DEDICATED TO IMPROVING THE HEALTH CARE RECEIVED BY HIGH RISK, LOW-INCOME, SUBSTANCE ABUSING PREGNANT WOMEN AND THEIR INFANTS UP TO ONE YEAR OF AGE.

ON BEHALF OF MARY'S CENTER'S STAFF AND ITS BOARD OF DIRECTORS I WOULD LIKE TO THANK YOU FOR INVITING ME TO SPEAK TO YOU TODAY. I HOPE THAT THE FEDERAL GOVERNMENT AND THE DISTRICT OF COLUMBIA WILL CONTINUE TO MAKE IT POSSIBLE FOR CLINICS LIKE MARY'S CENTER TO PROVIDE ACCESSIBLE, AFFORDABLE AND QUALITY HEALTH CARE TO LOW-INCOME, AND UNINSURED WOMEN AND CHILDREN OF OUR CITY. THANK YOU VERY MUCH.

Chairwoman SCHROEDER. The next witness we have this morning is Judith Jones, and we welcome you. Thank you for being here.

STATEMENT OF JUDITH JONES, ASSOCIATE CLINICAL PROFESSOR AND DIRECTOR, NATIONAL CENTER FOR CHILDREN IN POVERTY, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH, NEW YORK, NY

Ms. JONES. Good morning, Chairwoman Schroeder and members of the committee. As you know, I am Associate Clinical Professor of Public Health at Columbia University, and Director of the National Center for Children in Poverty at Columbia University.

The National Center for Children in Poverty is, quite frankly, in its infancy. It's only two years old and was established with major support by The Ford Foundation and the Carnegie Corporation of New York.

In order to broaden consensus, (what we've been talking about a lot this morning) and the importance of prevention and early intervention, the Center analyzes and disseminates information about poor families and their children, and about the public policies and programs that are designed to meet their needs.

The Center works in three areas—early childhood education, maternal and child health, and is just beginning an investigation of what we mean by service integration and coordination.

There are three overarching principles that guide our work and that we believe are critical in order to enhance the health status and prospects of children whose families are poor.

First of all, responses to the health needs of children and their families must be multi-dimensional, and we cannot expect optimal progress toward the goal of improved child health, unless we make advancements on other vital needs of poor families, specifically, I mean income security, housing, and education; and, second, responses to the health care needs of children must be premised on the prevention of disease and on early intervention to remediate and limit the damage from health and developmental problems; and, third, responses to child health problems must be two-generational. Health care needs of children must be addressed in the context of families. Healthy parents and educated parents, as research confirms, particularly the education of the mothers, who are the primary caregivers in this nation, is absolutely critical if we want to improve the health of children. And parents must also be active partners in efforts to improve the health of their children.

Now, I've been asked this morning to very briefly review the findings of what we hope have been two very important reports that we've published in the last year. As you know, there have been large increases in the numbers of young children living in poverty in the United States—in fact, one out of four under the age of six live in poverty.

We published a report last year called Five Million Children, which described the numerous risks associated with poverty. Poor families are less likely, because of limited financial resources, to be able to arrange for quality child care, to provide a safe and nurturing home environment, and to access convenient and affordable health care.

Five Million Children highlighted the fact that primary health care needs of a large proportion of our poorest families with infants and young preschoolers are not met. And while we strongly believe that multiple social and economic strategies must be pursued to improve the quality of life for children in the long term, we also believe that comprehensive primary health care can make an immediate difference in improving the well being and development of infants and young children. By comprehensive care we mean what several others have spoken of this morning—high quality care, but we talk about family-centered pediatric care that provides continuity, and includes social services, health education, nutrition, parent support and parent education, all offered in easily accessible sites in the community.

The Center has recently expanded and refined its analyses that we conducted in Five Million Children, into a report called Alive and Well, which I hope the committee has had a chance to see. It is probably the most comprehensive review of what we know in the research about the indisputable linkage between poverty and poor health among children in this country.

We know that all of the negative health outcomes that we are looking at, are more predominant among poor children, and it makes the Center feel even more assured that unless we do something to improve the income of parents, we are not going to see dramatic increases in the health status of children in this nation.

The report also underscores something that each and every one of us knows in this room, and that is, the uneven public responses to the challenge of assuring high quality care. There are many instances when something becomes fashionable, and then we drop it because our attention is taken up with other things.

I think it is time that we realize that we are not going to make progress unless we stick with this issue; that innovation in and of itself is not sufficient; that what we need is plain, hard work to do what we know works, and we know, happily, that a lot of things work.

We also know that all of the programs that we've been talking about this morning, have only reached a fraction of those children who are eligible. The primary reason that children have not been reached is that funding, again, has not been adequate. We also know that there are other problems in delivering services, which we may want to touch on at some point in the question period, and that is the limited capacity of the service delivery system. As appealing as it might be to think of the number of models that we have talked about and alluded to this morning, we have a very limited service capacity, and we have extremely unfriendly institutional practices, extremely unfriendly, from the receptionist at the front door who is frowning, to the fact that we make people literally go through hoops to get basic care and, quite frankly, there isn't one of us sitting in this room who would tolerate it. It's quite amazing that there aren't massive riots in most of our major public clinics throughout this country.

The Center has also begun, despite all of this, to systematically examine what localities are trying to do in the face of all odds, across this nation. And by the way, I want to take a moment and note the important role of community health centers in this coun-

try; centers that were specifically designed to address many of the issues, including one-stop shopping that we have talked about this morning. Those 540 clinics throughout the nation have not received adequate funding. They cannot expand.

So, while we search for new innovations, it is also important to remember that we have important systems in place that need to be augmented, and that need to be adequately funded.

Let me talk a little bit about financial barriers in institutional practice. I know a lot about that because I'm with one of the major medical institutions in the world. It's called the Columbia Presbyterian Medical Center. Several years ago, I was asked to do something to increase the number of women getting into early prenatal care because there was an active outreach into the community to increase demand for services. We asked a very simple question.

What would happen if every woman in the community who was Medicaid-eligible, in the Washington Heights area of New York, wanted to get into Presbyterian Hospital promptly? What we discovered in a retrospective review of the records, was that it was taking women 90 days to get to be seen for prenatal care—90 days.

And the good news—don't shake your head too fast because we did something very innovative—we opened the doors so women could get in. What we did was a slight tinkering with how women would get on Medicaid.

The hospital, because of reimbursement, always had an inpatient Medicaid eligibility unit. So, we posed a very simple question to the hospital "Why don't we take one of those workers and put them in the outpatient clinics, in Ob-Gyn and, guess what? If you do that, we bet—and we're going to document it—that we can improve your cashflow because you're going to see women up-front and not when they enter the emergency room".

Well, to make a very long political story rather short, within two months we had reduced the wait for the Medicaid certification letter from up to three months, down to 18 days, and after a little bit more tinkering, women were seen for prenatal care within 10 days.

And the mystery in all of this is that at that time, the Medicaid application form for the largely Hispanic population of New York, only existed in English. It was ten pages of fine print. Women had to travel from 168th Street and Broadway to 34th Street, two fares, et cetera—I mean, I don't want to bore you with all of this—but it is important to keep in mind that even with the expansions in OBRA, unless we look at institutional barriers to care, they basically won't make any difference for large numbers of women. We have too long ignored the fact that it is impossible, even if you are entitled, even if you are eligible, to be able to breach that tremendous gulf between desire and actual receipt of services.

Roanoke County in Virginia, thanks to my colleague here who pointed me in their direction, has also addressed the barriers to getting into child health services by creating a private-public partnership that has, through the leadership of a very outstanding pediatrician, managed to get all of the pediatricians—I think except for two—in Roanoke, to see Medicaid-eligible children. And what is interesting is that over time, this program has become more comprehensive, because as soon as you start to intervene with at-risk

children or families, you realize you cannot just take care of that one presenting problem, so, the program now has a large family support piece to it that deals with counseling, parent education, applications for other services and housing, et cetera.

The interesting ingredient in this project is that there are nurses and social workers who act as care coordinators, to assure that physicians don't have to deal with the paperwork, that they don't have to spend too much time with a patient, and basically make it possible for them to see a larger number of children. I think it's something that bears watching because I think it contains elements that certainly could be copied elsewhere.

Given our time this morning, I don't want to go into great detail on a number of other programs that I talk about in my written testimony, but there's another one that I want to tell you about because it really gave me a tremendous amount of joy when I went to visit it. It's in Lexington, Kentucky. It was developed under the auspices of the Department of Social Services, and while it's not a health care program per se, this multi-service center, which is really a Cadillac of services, is located in this one beautiful architecturally impressive, award-winning facility. It is something that I think we all should take a look at. It just shows you what leadership and some dollars can do.

I don't think it's going to surprise you that many of the programs for poor people are poor programs. I think it's time for us to move beyond a store front. I think it's time for us to acknowledge that what we want for our most vulnerable children is what we want for all children, and stop acting like it's an exception to the American way of doing things.

And I certainly hope that you will have an opportunity, maybe with the committee, to visit this particular site because it handles health within a context of broader family needs.

And, finally, I think, we haven't spent enough time this morning talking about the kinds of staff we're really interested in, that are going to provide these exceptional services to families.

We not only need people that are knowledgeable within their particular discipline, we need people that really do understand the dimensions of poverty and what it does to families, and what it could do to any one of us over time, that sit here in this room.

And, so, I was pleased to see in Hawaii they have special classes, for physicians to get a better understanding of the risks that poor families face. I think that this type of program needs to be broadened elsewhere around the nation.

However, the diffusion of best practice will continue to be constrained by severely limited resources, and we all know that in this nation when we need the resources for the things that we think are important, we can find them. It's time that we decided that children are central to the future of this nation, that budget constraints are just smoke and mirrors—I don't believe that dollars are the obstacles. I come from Connecticut. I've seen what's just happened with the Bank of New England. We get very excited if we're going to have our major banks default, not if our children default.

So, I'm thrilled at the thought of your leadership of this committee because I believe it will be extremely important. I know your

work in the past, you will keep your "eye on the prize" on this, and we expect to see some really exciting things happening. Thank you very much.

Chairwoman SCHROEDER. Thank you very much, that was very helpful to find there's a few bright spots out there.

[Prepared statement of Judith Jones follows:]

PREPARED STATEMENT OF JUDITH JONES, ASSOCIATE CLINICAL PROFESSOR AND DIRECTOR, NATIONAL CENTER FOR CHILDREN IN POVERTY, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH NEW YORK, NY

Chairwoman Schroeder and members of the Committee, my name is Judith Jones. I am Associate Clinical Professor of Public Health and Director of the National Center for Children in Poverty at Columbia University in New York. I am pleased to provide testimony this morning on an issue that is vital to the future of our country: healthy children.

The National Center for Children in Poverty was established in 1989 at Columbia University with support from the Ford Foundation and the Carnegie Corporation of New York. The Center's goal is to strengthen policies and programs for poor children under six and their families. To achieve this goal the Center collects, synthesizes, and actively disseminates information about poor children and families, and about public policies and programs designed to address their needs. The Center is also initiating projects through which we will assist state and local agencies directly to plan and implement improved policies and promising program approaches in the fields of maternal and child health, child care, and service integration.

The Center has a strong interest in promoting the healthy development of children. While we recognize that multiple strategies must be pursued to improve child health, including measures that strengthen families and support their economic status, we have found that comprehensive primary care services can make an immediate difference in the well-being of infants and young children. By "comprehensive care" we mean accessible, high-quality, family-centered pediatric care that includes social services, health education, nutrition, and referrals for hospitalization and other specialized services. We also believe that these services should be offered in the neighborhoods where poor families live.

There are larger numbers of young children living in poverty today than ever before. The Center's publication last year of *Five Million Children: A Statistical Profile of Our Poorest Young Citizens*, describes the risks faced by a fully a quarter of all children under six in this country. Poor children, compared to low- and middle-income children, are more likely to suffer from problems related to prematurity and low birthweight, poor nutrition, accidental injury, child abuse and neglect, and more recently, from AIDS and prenatal drug exposure. Their families are less likely to be able to arrange for quality child care, to provide a safe, nurturing and intellectually stimulating home, and to find a convenient and affordable source of primary health care. The report stressed that the primary health care needs of a large proportion of our poorest infants and young preschoolers are still *not met*.

We continued our analysis of health issues for infants and young children in poor families by commissioning a review from Dr. Lorraine V. Klerman, Professor of Public Health at Yale University. The recently published monograph *Alive and Well? A Program and Policy Review of Health Programs for Young Children* examines, in a comprehensive fashion, the indisputable evidence linking poverty to poor birth outcomes, increased illness, and increased mortality among infants and children in very low-income families. Causes of death higher among poor children than nonpoor children include sudden infant death syndrome (SIDS), unintended injuries, child abuse, and infectious diseases, including AIDS. Health problems that the poor suffer disproportionately include low birthweight, HIV infection, asthma, dental decay, measles, nutritional problems, lead poisoning, learning disabilities, unintentional injuries, and child abuse and neglect. Poor infants and children also have higher rates of hospitalization than their nonpoor peers.

Like *Five Million Children*, the Klerman report also stresses that major improvements in the health and well-being of infants and children in disadvantaged families will only be achieved through substantial commitments at all levels of government to

reducing poverty rates, enforcing broad environmental public health measures, and expanding the number of health care organizations willing and able to provide the range of services poor families need. These include injury prevention, lead abatement, nutritional supplements, immunization, family planning, prenatal care, and primary health care in poor neighborhoods.

Throughout this century our federal government has adopted a "limited-scale" intervention strategy in dealing with the health and welfare of poor children—beginning with the establishment of the Children's Bureau in 1909 and its 1920s role in implementing maternal and child health activities and expanding public health nursing. In 1935, passage of Title V of the Social Security Act led to comprehensive health programs for handicapped children, school health programs, and prenatal and well-baby clinics. Poor families with sick children, however, were still left to seek charity from public hospitals and kind physicians.

Beginning with the 1960s War on Poverty, a number of new initiatives expanded access to primary and curative services, including Medicaid, enacted in 1965 under Title XIX of the Social Security Act, WIC, Head Start, and some demonstration projects funded through grants. For much of this period, however, there was little program expansion, and some of the demonstration projects have been phased out. Not all of these programs have been entitlements, and the federal grant programs have not begun to cover the needs of poor children in many communities. Coverage of services, eligibility requirements and procedures, and implementation of entitlement programs varies widely from state to state. Even the recent OBRA expansions of Medicaid in 1986, 1987, and 1989 are not being fully or rapidly implemented in many states.

Organizers of primary care services for infants and children in poor families must take the situation of the parents into account if those services are to be used and to be effective. Poor parents find it very difficult to fill out one Medicaid application form; the form is sometimes as long as 45 pages. They may not fathom why immunizations cannot be given in the office of the private physician who treats the infant during illness. They may not catch the significance of the letters "EPSDT," when mumbled by a caseworker after a long session filling out the Medicaid application. Working parents may find it difficult to be absent from work for several hours to take their children for immunizations or vision and hearing screenings scheduled only during working hours between Monday and Friday.

The conclusions of the report Alive and Well? refer to specific strategies for improving health services for low-income mothers and children. I will comment on three broad strategies:

- We need to reorganize our existing services. Some communities appear to believe that additional programs are the only solutions to problems. Often, however, positive results can be achieved by modifying bureaucracies and exploring the strengths and weaknesses of programs, followed by procedural improvements and more "user friendly" practices. State and local health departments can work with private institutions to avoid duplications in maternal and pediatric care, and they can work with community agencies to create rational systems and expand networks of primary care facilities. And they can enhance limited-service clinics to be more comprehensive.

- We need to change unfriendly institutional practices. Barriers to quality care often loom larger *inside* the doors of health care facilities for the poor than outside. Long waiting lists for appointments, haphazard referral and follow-up, and insensitivity to the financial, child care, and transportation problems faced by low-income parents can all be modified through creative management and staff retraining. Making determinations of eligibility for Medicaid at the site of care has become more common as more and more institutions have realized that this practice can improve reimbursement rates.

- We need to modify the content and delivery of care. Many pregnant women and children face risks that cannot be reduced by the same type of prenatal and pediatric care considered adequate for middle-income families. For these families, the services of social workers, nutritionists, and public health nurses are essential. The education and services provided by these professionals, frequently through home visiting, promotes appropriate health care utilization and enhances the benefits of medical care.

The National Center for Children in Poverty has begun to examine systematically the programmatic features of state and local primary health care initiatives that appear to meet poor families' needs and improve the quality of care their children receive. I will describe some of these features here and illustrate how they work in practice by mentioning a few examples. I should note first, however, that the nation's 600 or so community health centers were purposely designed to be sources of comprehensive health care for the poor and uninsured. Their funding source, structure, philosophy,

and links to community organizations enable them to play an important stop-gap role in the ever-widening breach of unmet need for health care. They frequently house WIC, well-baby checkups, prenatal care, pediatric care, and social services at one location, and many of these centers are doing an excellent job.

1. **First, the program must facilitate financial access to care upon entry.**

   In many communities, poor and uninsured families cannot find a doctor in their neighborhood who will accept new Medicaid patients or reduced fees, and there are no clinics outside the hospital that will see sick children. Roanoke county in Virginia solved this problem by creating a public private partnership between primary care physicians, the county health department, and a community action agency. Children from families with incomes below 150% of poverty are assigned to one of 34 physicians who sees them for check-ups as well as when they are sick. These physicians bill Medicaid or the program at Medicaid rates for their services. Nurses and outreach workers who make home visits help eligible families fill out the Medicaid application, take care of pressing housing and financial needs, keep their doctor's appointments and follow medical advice. The mother learns the name and the telephone number of someone to contact 24 hours a day if she has questions or in case of emergencies.

   Several years ago, I helped the Prenatal Clinic at New York City's Presbyterian Hospital address financial access with two interventions. First, we placed a nurse midwife and a bilingual health advocate in the pregnancy screening clinic to identify pregnant women in need of care. The second and most important of these interventions was the creation of a new Medicaid eligibility unit in the outpatient clinic that assisted the women to fill out a Medicaid application and make an appointment with the Medicaid office. The results were dramatic: waiting time for Medicaid certification was reduced from six weeks to 18 days! Today, presumptive eligibility, expanded Medicaid eligibility, and reduced-fee packages have lessened some financial-access barriers in many communities. But too many pregnant women and mothers who visit an institution for the first time fail to encounter a friendly someone who can tell them that their financial problems will not prevent them from seeing a doctor.

2. **Second, the program must recognize the nonmedical or environmental risks that the infant or child faces.**

   The staff in Hawaii's Healthy Start program, now operating in many counties, screen newborns in the maternity ward for potential risk of abuse and neglect.

Their screening checklist helps nurses identify family difficulties and lack of social support that may impair a mother's ability to care for her newborn. They offer a voluntary home-visiting and family support program to deal with family and parenting problems. Moreover, they link the infant to a regular source of pediatric care.

Eight pediatric resource centers in New York City, most of them linked to hospitals, provide quality family-centered pediatric care annually to nearly 25,000 children at high-risk for poor health outcomes. They have developed standards of care for different priority conditions, including parenting problems, associated with high levels of morbidity and mortality in infants and children from low-income families. The families of children with conditions of greater severity receive focused attention and a variety of services from nurses, social workers, nutritionists, and other specialists. A formal review process periodically assesses the degree to which these standards are being met.

3. **Third, the program must be both comprehensive and coordinated around the needs of the child.**

Preventive services and medical care must be offered as a single package, together with services and arrangements that enable low-income families to use them. A variety of approaches can approximate a comprehensive system of care. Some state MCH and Medicaid programs have initiated care coordination or case management for high-risk pregnancies and infants. For example, Mississippi is expanding a demonstration program that uses interdisciplinary teams of nurses, social workers, and nutritionists to help poor families find and use all of the services—not only medical— that their infant needs.

A relatively new program in Lexington, Kentucky, illustrates "one-stop shopping" for services funded by many different sources. A single-site multiservice center not only provides health care, dental care, and psychological services, but also transportation, child care, job training, parenting education, and GED certification. Scheduled case conferences help staff members coordinate client services and respond to changing family situations.

Where services are not located in the same location, different professionals must coordinate their efforts through case conferences or shared data systems. One public/private community pediatric program reports that the use of a fax machine has greatly facilitated the process of transferring information and medical records from clinic to hospital to social service departments.

4. **Fourth, the program should promote recruitment and training policies that result in a staff that is compassionate, sensitive, and knowledgeable about the needs of low-income families.**

   Ideally, professional training of doctors and nurses should include an exploration of the underlying risk factors responsible for much of today's morbidity and mortality. Subtle developmental delays, neglect caused by substance abuse, homelessness or near-homelessness, obesity, or "failure to thrive" symptoms may be correctable if appropriate social and mental health services are available in time and if the family receives help in using the services. Young parents also need counseling about how to identify symptoms and signs of developmental delay.

   Physicians also need training that emphasizes the value of public health nurses, social workers, lay home visitors, and child care workers. These professionals can be far more important to child health than high-technology medical care, yet they are often in short supply, undervalued, and paid wages from 5 - 8 times less than a primary care physician. We have learned that Hawaii has begun a continuing education program for physicians that stresses the importance of early identification and treatment of child development problems, and that teaches new skills to deal with emotional and developmental problems.

The features of the various programs presented here are practices that can be adopted elsewhere by state and local health and social services workers who find the current situation in child health unacceptable.

We must recognize, however, that there are multiple constraints on the diffusion of good practice. There may be a lack of favorable state policies and fiscal resources, a lack of flexible funding resources, a lack of standards and quality assurance procedures, an insufficient health and social service infrastructure, an inability to pay competitive wages to recruit and retain good staff, and a lack of managerial resources at the local level.

As we learn more about promising and evolving programs, however, we see that local demonstrations *have* influenced state policies and programs, and that state initiatives in turn have encountered and overcome local implementation barriers. Innovative programs that survive, adapt, and expand ultimately depend on the people and the communities driving them. Successful expansions are likely to be

based on broad-based political strategies to build coalitions and communicate frequently with state agencies and legislators, to increase productivity and seek new funding sources, to modify staff caseloads, to adapt services creatively to fit new funding streams, and to employ effective social marketing techniques that help educate the clientele and create a demand for improved health services.

This country has experienced a large-scale mobilization of resources to improve maternal and child health in the face of a national emergency. That emergency was World War II, which created a crisis for many low-income mothers who could not find health care. The program was the Emergency Maternity and Infant Care Program (EMIC), which provided health care to a million and a quarter low-income women and infants from 1943 to 1948, strengthened state and local health departments, and established national standards of care and coverage. Perhaps some day soon we will recognize the continuing national emergency that confronts our poor families, and mount a national strategy for child health that will effectively assure comprehensive quality primary health care for all infants and young children.

Chairwoman SCHROEDER. Kay Johnson, we thank you for your patience and waiting. We know you've been working hard in this area, we look forward to your testimony, and welcome.

STATEMENT OF KAY JOHNSON, SENIOR HEALTH POLICY ADVISOR, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WASHINGTON, DC

Ms. JOHNSON. Thank you.

Chairwoman Schroeder and members of the committee, I am very pleased to have this opportunity to speak on behalf of the March of Dimes this morning.

The March of Dimes has as its goal the prevention of birth defects and the birth of healthy babies. We believe that as a nation, there's a moral and financial obligation to provide quality child health care, and that it begins before birth with comprehensive maternity care.

To our volunteers and staff all over the nation, the March of Dimes works to help the nation have healthier babies. Through biomedical research, and whether that's through gene therapy or new infant vaccines, we can help expand the horizons of prevention and save ourselves millions of dollars. Working in communities, members of the March of Dimes and the volunteers, we are serving families, to direct services, health education programs, and policy leadership.

We are very encouraged by the fact that infant mortality is now a high political priority both on and off of Capitol Hill, and we applaud all of this committee's efforts to push this issue to the position that it holds today, and we are very pleased as well that you are continuing to work on all fronts, for assuring children's good health and development.

We know that our investments in improving health yield dividends for families and for the nation's communities all over the country. The alternative is economic cost that we simply cannot afford.

I think you've heard a lot of evidence about the knowledge that we have to solve a lot of our problems. We know that the knowledge is not being applied uniformly to the benefit of all of our children. We believe that it should be applied for the benefit of all of those children, regardless of their color or the economic status.

We also know that additional resources are going to need to be applied to research if we are going to broaden the horizons of prevention. We are not reaping the seeds that we have sown in biomedical research, to do things that are very positive in those areas.

I have submitted longer testimony for the record. I just want to briefly highlight some of my findings and recommendations. We have been asking ourselves over and over again, I think, the question, has the nation made adequate progress in reducing infant mortality rates as a leading indicator of maternal and infant health?

Regrettably, we haven't made adequate progress, but we have some encouraging signs. We've heard about the recently released provisional infant mortality rates that demonstrated a decline between 1989 and 1990, after a long, dry period since 1981.

If a substantial portion of that progress is the result of increased efforts of prevention, then we may be on the right track. If we are simply doing another magic technological trick, we know that those gains will not hold, they will not be sustained over the coming years.

Experts have consistently told us that early and comprehensive prenatal care can help prevent low birthweight, that it can stop substance abuse among pregnant women, that it can provide an opportunity to treat and diagnose a variety of conditions that may lead to birth defect or unhealthy birth. In turn, that's how we reduce infant mortality. We do it very simply by going through the motions of providing good care for those women.

A report released this week on infant mortality in New York City found that improved access to prenatal care really did have an effect on reducing infant mortality rates in New York City, an area many of us may see as an impossible area in which to succeed.

The March of Dimes notes with interest and was involved in the analysis that infants born to substance-abusing women who had received comprehensive prenatal care, were one-third less likely to die than infants who were born drug-exposed to those women who had later prenatal care. Even when the woman was using drugs during the pregnancy, that comprehensive prenatal care made the difference. That's how we can get women to stop using drugs.

We also know there are a lot of barriers to families as they go to seek care. I have been working on the issue of maternity care. I've also been working on the issue of immunization a lot over the past years. We know that there is a very unfriendly system out there, and that when families approach it they see many barriers, that families seek care and are denied, that families can't get to care because they are two bus rides away.

The Institute of Medicine provided us formal documentation of the fact that "a maternity care system is fundamentally flawed, fragmented, and overly complex." We've had other researchers who tell us that while knowledge, attitudes and beliefs of pregnant women may keep them out of care, they may be afraid to go, they may not understand the importance of care, at the same time, minority women even with the same knowledge and attitudes, have less access to care. They live in communities where providers may not be willing to see them, or providers may not be available under any circumstances.

We also know—and this begins to get at the crux of where does integration begin to make a difference—that women who are seen in public health clinics are more likely to have received comprehensive prenatal care. We know that isolating women in a private physician's office, if they need a wide range of services, is not going to achieve the desired results. And we have to think about ways to integrate our public and private systems better.

There are a range of public and private programs that have been designed to apply the lessons—Judy Jones knows those programs far better than I, as she is a self-described "program person"—leading all of us into a better understanding of what works.

We know that states who have moved aggressively to implement Medicaid, identified women and brought them into care, and reduced infant mortality rates. We know that public officials at the

federal, state and local level, who have taken those steps through integration of services as are in the commission's report this morning, have shown how to make a difference.

We know that private funders are financing public awareness campaigns, worksite prenatal education programs, and a variety of other things that are going to make a difference. That is not going to get the job done completely. We do need a nationwide strategy.

Given the enormous cost of not taking action, we have a series of recommendations. We hope that members of Congress will this year make the decision to provide Medicaid coverage for pregnant women and infants in every state, up to 185 percent of the federal poverty level. Those near-poor working women up at the top end of that income range are among those most likely to give birth to a baby and still be uninsured.

We know that we have medically underserved areas where the Maternal and Child Health Block Grant and community health centers are the way to make a difference. We know that the WIC program works, and that we ought to be more adequately funding it.

We have innovative infant mortality reduction strategies that could be being applied, and that in more than 20 of the nation's cities and dozens of rural counties there are infant mortality rates at 1.5 times the national average.

The Administration has proposed an infant mortality reduction initiative described to you this morning by Dr. Harmon. We recommend that any target infant mortality issue be funded with new resources, and incorporate the lessons learned from demonstration programs.

We need to think more about drug treatment and drug and substance abuse prevention. We need to think about the coordination and integration of services through linking related entitlement programs, uniform eligibility criteria, simplified enrollment procedures, comprehensive range of services being delivered in those systems, and emphasize preventive services such as immunization and prenatal care, and maximize opportunities for co-location of services.

In closing, I'd like to mention just a couple of the lessons that have been learned again, through recent efforts to improve maternal and child health. Many of them have actually been documented by the committee over the years, but perhaps foremost among these lessons is that every sector of society has a role to play.

We've learned that success is going to require a balance of Federal Government leadership and state and local government creativity, but it really is a balance. It's also very clear to us that health professionals cannot tackle problems such as infant mortality alone, that they are not the health professionals alone who can solve the problem because it is a societal problem. There needs to be a community development perspective applied to these problems, and a coordinated approach is essential.

Finally, we know that sustained effort is going to be required. We cannot expect overnight change. Officials in Utah tell us that the combination of an outreach campaign for pregnant women all over the state, at every income level, combined with the extension of Medicaid for low-income women, yielded dramatic results. It re-

duced infant mortality among low-income women. It reduced low birthweight births among low-income women, but it took them three to five years, and they don't believe they could have done it in any less time than that.

In other areas, well integrated and comprehensive community-based systems have been developed, however, the strength of those systems is years of coalition-building and infrastructure-building. We may not have the physical facilities, we may not have the cooperative agreement, we may not have the members of communities talking to each other and professionals talking to them. All of those efforts require community involvement and administrative structures for support, a balance of those things. We know that these things take time, and they are going to take resources.

I really appreciate your attention, and I look forward to responding to any questions you might have.

Chairwoman SCHROEDER. Thank you, and we want to thank the entire panel for their very, very good testimony, both written and oral.

[Prepared statement of Kay Johnson follows:]

PREPARED STATEMENT OF KAY JOHNSON, SENIOR HEALTH POLICY ADVISOR, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WASHINGTON, DC

Chairwoman Schroeder and Members of the Committee, I am pleased to have this opportunity to discuss strategies for improving the health of America's infants and children. The March of Dimes has as its goal the prevention of birth defects and the birth of healthy babies. We believe that every child, regardless of color or economic status, deserves the best possible health and that we as a nation have an obligation to provide child health care -- beginning before birth with comprehensive maternity care.

Investments in improving infant health yield personal dividends for families and communities, as well as financial savings to society. The alternative is higher human, social, and economic costs our nation cannot afford. We have the knowledge to solve many problems in maternity and infant care. This knowledge must be applied to the benefit of all of our children. In addition, we believe additional resources must be applied to further advance our capacity for prevention through research about the causes of birth defects and infant death.

The more complete written testimony I have submitted for the hearing record addresses two questions of special concern to today's topic.

1. Has the nation made adequate progress in reducing infant mortality rates and on other key maternal and child health indicators?

2. What barriers to health care are faced by families seeking maternity and infant health services, and what do we know

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about strategies for reducing barriers to access and improving the health of mothers and babies?

In my oral remarks, I will review briefly some responses to these questions and close by making recommendations for improvement in maternal and infant health programs.

I. Has the nation made adequate progress in reducing infant mortality rates and other key maternal and infant health indicators?

Regrettably not, but recent signs are encouraging. Each year approximately 38,000 of the over 3.4 million children born in the United States die before their first birthday. [1] Following two decades of rapid decline, the nation's progress in reducing infant mortality was very slow between 1981 and 1989. During the 1970s infant mortality rates fell at an average of 4.7 percent per year, as compared to an average of 2.8 percent per year for the 1980s. [2] Between 1987 and 1988 (the most recent year for which complete final data are available) there was no statistically significant decline in the nation's overall infant mortality rate. [3]

Furthermore, the nation has failed to make progress in closing the black/white infant mortality "gap." [4] Despite some reductions in the black infant mortality rate, black infants continue to die at more than twice that of white infants. For the years 1987 and 1988, the black/white infant mortality gaps were the greatest ever recorded (2.08-to-1 and 2.07-to-1 respectively). [5]

Recently released provisional infant mortality rates indicate a more dramatic decline between 1989 and 1990. (However, only complete final statistics will tell us how much and where progress was made.) If, as some federal officials suggest, the decline was attributable to new drug therapies for tiny newborns, significant additional gains cannot be expected in coming years. The experience of the 1970s demonstrated that progress through technological advances in saving more of the excess number of infants born too soon and too small will level off before we reach our goals. If, on the other hand, a substantial portion of progress in the past two years was the result of increased efforts to improve access to and the quality of prenatal care and thereby prevent infant health problems, the nation may be on the right track.

In 1989 the United States ranked 19th worldwide in infant mortality. [*] International comparisons also reveal that the nation ranks last among our industrialized peers. Experts point to numerous factors that account for our nation's failure to reduce infant mortality as rapidly as other industrialized countries. The first is a relatively high proportion of low birthweight births. The United States ranks 28th in low birthweight worldwide -- tied with Kuwait, Israel, the United Kingdom and other nations. [*]

Low birthweight (birth at less than 5.5 pounds) and prematurity (birth prior to 37 weeks gestation) are the most important factors in predicting infant survival and health. [*]

The incidence of low birthweight in 1988 remained virtually unchanged from 1979 to 1988. [8] Studies have demonstrated the link between low birthweight and access to medical and nutritional services during pregnancy. [9] As a nation, we have failed to put to use what we do know about prevention of low birthweight. For example, the Supplemental Food Program for Women, Infants, and Children (WIC) has been demonstrated to be effective in reducing low birthweight and prematurity rates. [10] Yet only half of the eligible population can be served with available funds.

The problem of low birthweight is exacerbated (but by no means caused solely) by our rate of teenage childbearing, which exceeds that of other industrialized nations. Teenage childbearing is a nationwide problem. In 1988 teens accounted for 13 percent of all births, but 17 percent of low birthweight births. [11] Research indicates that higher incidence of low birthweight among babies born to teens is related more to their mothers' reduced access to prenatal care than to their mothers' young age. [12]

Access to maternity services is another key factor which distinguishes the United States from the countries that have the lowest infant mortality rates. Our nation stands alone among its peers in the failure to assure all pregnant women access to prenatal and delivery services through either a public health service or universal health insurance. Furthermore, our public maternity policies lag far behind those of dozens of other

nations which ensure the provision of basic health and social supports such as medical and nutritional care and some form of income support or protection (such as a family allowance or a parental leave policy). "

Inadequate prenatal care can have serious implications for infant health. The more than 70,000 infants who are born each year to women who receive no prenatal care are 20 times more likely than those who have the benefit of adequate care to die in the first year of life. Experts consistently report that early and comprehensive prenatal care can help prevent low birthweight, stop substance abuse, and provide an opportunity to diagnose and treat conditions that may lead to birth defects. In turn, the number of infant deaths can be reduced.

- For example, a report released this week on infant mortality in New York City found that improved access to prenatal care helped to reduce infant mortality. The March of Dimes analysis accompanying the report noted with interest a finding that infants born to substance abusing women who had received comprehensive prenatal care were one-third less likely to die in the first year as infants born drug exposed to women who received late or no prenatal care. "

- The Institute of Medicine found that prenatal care for low income women saves $3 for every $1 invested through prevention of low birthweight and reduction of the need for high cost neonatal intensive care."

National, state, and local studies indicate positive new directions in use of maternity care and new treatments. Interventions delivered during pregnancy as part of a comprehensive prenatal care program for minimizing the potentially damaging effects of birth defects, substance abuse, infections, and other conditions of pregnancy have demonstrated

success in improving birth outcomes. Preliminary evidence of abatement in the New York City crack cocaine epidemic also is promising.

II. What barriers to health care are faced by families seeking maternity and infant health services and what can be done to reduce such barriers?

Much has been learned in recent years about barriers to access to maternity and infant health services. The Institute of Medicine, in reviewing studies of barriers to care conducted in communities across the nation, found "a maternity care system that is fundamentally flawed, fragmented, and overly complex." [*] From New York City to Oklahoma City, the chief obstacles were financial.

- The cost of having a baby is increasing. By 1989 the average cost of maternity care was over $4,000 for a normal delivery, with hospital charges accounting for nearly three-quarters of the costs. [**]

In addition, the Institute of Medicine committee found that basic system capacity is inadequate and that policies and practices (such as discouraging program enrollment procedures, long waits for appointments, and inadequate clinic hours) were virtually insurmountable barriers for families in some areas. A set of personal and attitudinal factors, such as lack of awareness of services and dislike or fear of prenatal care, contribute to low demand for services, even where they are accessible.

Another recent study examined the relationships between the personal motivations of pregnant women, the publicly funded programs intended to serve them, and pregnancy outcomes. The survey included 32 communities in eight states. " Researchers found:

- Enrollment in Medicaid and participation in state prenatal programs improved use of prenatal care and reduced low birthweight.
- Knowledge, attitudes, and beliefs about prenatal care affected use of services. However, even after these factors were taken into account, minority women had substantially less access to prenatal care. These differences may be attributable to limited numbers of providers or providers unwillingness to treat minority women.
- Women whose regular source of care was a community clinic or hospital outpatient department received more prenatal care and had babies with better birthweights than women using private physicians.

The U.S. General Accounting Office (GAO) reported to this Committee in February on Early Success in Enrolling Women Made Eligible by Medicaid Expansions. " The GAO found some activities had a dramatic effect on Medicaid enrollment of newly eligible groups of low income women for the two year periods in the late 1980s studied in 10 states. Several factors were found to be likely contributors to success.

- States which implemented presumptive (accelerated, on site) eligibility procedures and dropped asset tests experienced the most rapid initial growth in enrollment.
- Other publicly funded programs serving low income women, as WIC, have a role to play in bringing women into the public health services system.
- Outreach and public information campaigns may have been successful in informing pregnant women about the expansions.

Preventive and primary health care services continuing throughout the first year of life also are important. Failure to provide routine preventive health care for one out of every eight poor infants leads to unnecessary disease, disability, and death. For example, despite available effective and low cost treatments, pneumonia continues to be among the ten leading causes of infant death. In addition, outbreaks of preventable childhood disease such as measles, pertussis (whooping cough), and rubella (German measles) have occurred in recent years. These conditions can be life threatening for infants. The National Vaccine Advisory Committee has reported that inadequate access to primary health care among infants and toddlers are a major contributor to low immunization rates and the resulting outbreaks of preventable disease. [21]

A range of public and private programs have been designed to apply the lessons learned from these studies. Additional states have moved to more aggressively implement Medicaid expansions for women and children. Public officials at the federal, state, and local level have begun to take steps to better coordinate and integrate maternal and child health programs. Private funders are financing public awareness campaigns and worksite prenatal education programs (the March of Dimes "Babies and You" program is one such initiative). However, a nationwide strategy is needed.

III. Given the enormous human and fiscal costs of infant death and disability, the March of Dimes recommends improvements in key preventive maternal and child health and nutrition programs.

1. All families should have access to affordable, adequate health insurance, particularly maternity coverage. A next step in filling the maternity coverage gap would be to require states to provide Medicaid to pregnant women and infants with family incomes up to 185 percent of the federal poverty level. Currently, approximately 18 states have elected to extend coverage to that level. "

2. All families should have access to appropriate health providers. We recommend that funding for the Title V Maternal and Child Block Grant and the Community and Migrant Health Centers program be sufficient to permit the development of comprehensive maternal and infant health services in all medically underserved areas.

3. No woman, infant, or child who is eligible for supplemental nutrition assistance under the WIC program should go without these benefits. We support increased funding to improve participation rates for low income and nutritionally at-risk pregnant women, infants and children.

4. Innovative infant mortality reduction strategies are needed in some communities; in others, we simply need to apply strategies already known to be effective. More than 20 of the nation's cities and dozens of rural counties have infant mortality rates more than 1.5 times national average. The

Administration has proposed an infant mortality reduction initiative, Healthy Start, for 10 communities. We recommend that any targeted infant mortality initiative be funded with new resources and incorporate lessons learned from recent demonstration projects. New community projects should be family-centered, community-based, and aim to better integrate services, and provide comprehensive maternity and infant health services. Policymakers should also bear in mind that model programs have shown that sustained effort, rather than attempts at quick fixes, yield results. The March of Dimes looks forward to working with Congress and the Administration on developing effective strategies and partnerships to ensure the success of a new infant mortality reduction initiative.

5. More drug treatment programs for pregnant women are urgently needed. It is clear that thousands of lives and millions of dollars could be saved through prevention and treatment of drug use during pregnancy. Strategies have been proposed for funding cost-effective residential drug treatment services for women of childbearing age through Medicaid. States should be encouraged and given the option to enact such expansions.

6. The delivery of maternal and child health services should be enhanced through better coordination and integration. Demonstration projects should be established through the Department of Health and Human Services to test "one-stop shopping" models. Such projects should: link related entitlement programs through uniform eligibility criteria; simplify

enrollment procedures and application forms; offer a comprehensive range of health and social services; emphasize preventive services such as immunization and prenatal care; and maximize opportunities for co-location of services. Authority for such projects currently exists in the Title V Maternal and Child Health Block Grant statute, but no funds have been appropriated to launch ten projects.

V. Conclusion

As early as 1910, the Children's Bureau began to document maternal and child health problems and origins. In a series of studies of 10 communities, the Bureau found a startling coincidence of poverty with infant mortality. As is true today, the leading causes of death included prematurity and birth defects. Inadequate access to preventive prenatal and infant health services were seen as a primary cause. The March of Dimes believes that the nation has waited too long to address these problems head on and must take steps now to ensure that all pregnant women have access to comprehensive maternity care. We are encouraged by the fact that infant mortality is now a high political priority, and we applaud all of this Committees' efforts to push this issue to the position it holds today.

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(Deaths of children under one year old, per 1,000 live births)

Year	All Races	----Nonwhite---- White	Black	Total	Ratio of Black to White	All Races % Drop From Prev. Year
1990	9.1	(provisional data)		N/A	N/A	6.19
1989	9.7	(provisional data)		N/A	N/A	3.00
1988	10.0	8.5	17.6	15.0	2.07	0.99
1987	10.1	8.6	17.9	15.4	2.08	2.88
1986	10.4	8.9	18.0	15.7	2.02	1.89
1985	10.6	9.3	18.2	15.8	1.96	1.85
1984	10.8	9.4	18.4	16.1	1.96	3.57
1983	11.2	9.7	19.2	16.8	1.98	2.61
1982	11.5	10.1	19.6	17.3	1.94	3.36
1981	11.9	10.5	20.0	17.8	1.90	5.56
1980	12.6	11.0	21.4	19.1	1.95	3.82
1979	13.1	11.4	21.8	19.8	1.91	5.07
1978	13.8	12.0	23.1	21.1	1.93	2.13
1977	14.1	12.3	23.6	21.7	1.92	7.24
1976	15.2	13.3	25.5	23.5	1.92	5.59
1975	16.1	14.2	26.2	24.2	1.85	3.59
1974	16.7	14.8	26.8	24.9	1.81	5.65
1973	17.7	15.8	28.1	26.2	1.78	4.32
1972	18.5	16.4	29.6	27.7	1.80	3.14
1971	19.1	17.1	30.3	28.5	1.77	4.50
1970	20.0	17.8	32.6	30.9	1.83	4.31
1969	20.9	18.4	34.8	32.9	1.89	4.13
1968	21.8	19.2	36.2	34.5	1.89	2.68
1967	22.4	19.7	37.5	35.9	1.90	5.49
1966	23.7	20.6	40.2	38.8	1.95	4.05
1965	24.7	21.5	41.7	40.3	1.94	0.40
1964	24.8	21.6	42.3	41.1	1.96	1.59
1963	25.2	22.2	42.8	41.5	1.93	0.40
1962	25.3	22.3	42.6	41.4	1.91	0.00
1961	25.3	22.4	41.8	40.7	1.87	2.69
1960	26.0	22.9	44.3	43.2	1.93	1.52

(Deaths of children under one year old, per 1,000 live births)

Year	All Races	White	----Nonwhite---- Black	Total	Ratio of Black to White	All Races % Drop From Prev. Year
1959	26.4	23.2	44.8	44.0	1.93	2.58
1958	27.1	23.8	46.3	45.7	1.95	-3.04
1957	26.3	23.3	44.2	43.7	1.90	-1.15
1956	26.0	23.2	42.4	42.1	1.83	1.52
1955	26.4	23.6	43.1	42.8	1.83	0.75
1954	26.6	23.9	42.9	42.9	1.79	4.32
1953	27.8	25.0	44.5	44.7	1.78	2.11
1952	28.4	25.5	46.9	47.0	1.84	0.00
1951	28.4	25.8	44.3	44.8	1.72	2.74
1950	29.2	26.8	43.9	44.5	1.64	6.71
1949	31.3	28.9	46.8	47.3	1.62	2.19
1948	32.0	29.9	45.7	46.5	1.53	0.62
1947	32.2	30.1	47.7	48.5	1.58	4.73
1946	33.8	31.8	48.8	49.5	1.53	11.75
1945	38.3	35.6	56.2	57.0	1.58	3.77
1944	39.8	36.9	59.3	60.3	1.61	1.49
1943	40.4	37.5	61.5	62.5	1.64	0.00
1942	40.4	37.3	64.2	64.6	1.72	10.82
1941	45.3	41.2	74.1	74.8	1.80	3.62
1940	47.0	43.2	72.9	73.8	1.69	N/A

SOURCE: National Center for Health Statistics

Infant Mortality Rates, by Race, 1965-1988

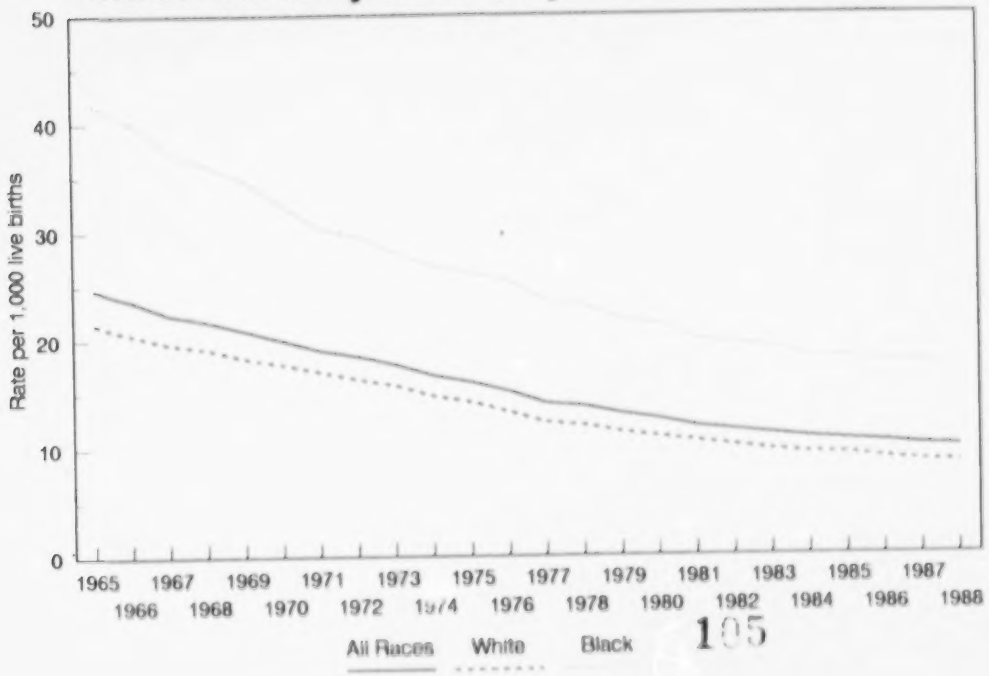

Table 3 Trends in Infant Mortality Rates, By State, All Races, 1978-1988

State	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Alabama	16.1	14.4	15.1	13.0	13.8	13.1	12.9	12.6	13.3	12.2	12.1
Alaska	14.4	15.9	12.3	12.7	11.1	12.4	11.2	10.8	10.8	10.4	11.6
Arizona	13.1	13.6	12.4	11.8	9.3	9.5	9.5	9.7	9.4	9.5	9.7
Arkansas	16.4	13.4	12.7	11.9	10.1	10.7	10.9	11.6	10.3	10.3	10.7
California	11.8	11.2	11.1	10.2	9.9	9.7	9.4	9.5	8.9	9.0	8.6
Colorado	11.2	10.6	10.1	10.0	9.1	10.0	10.2	9.4	8.6	9.8	9.6
Connecticut	11.6	12.1	11.2	12.1	11.1	10.1	10.4	10.0	9.1	8.8	8.9
Delaware	13.2	17.0	13.9	13.4	14.1	10.0	10.8	14.8	11.5	11.7	11.8
District of Columbia	27.3	22.2	25.0	25.1	21.2	19.3	21.0	20.8	21.1	19.3	23.2
Florida	14.1	14.9	14.6	13.3	12.8	12.2	10.8	11.3	11.0	10.6	10.6
Georgia	15.4	15.1	14.5	13.8	12.7	13.4	12.9	12.7	12.5	12.7	12.6
Hawaii	11.1	10.0	10.3	9.8	8.8	9.4	9.9	8.8	9.3	8.9	7.2
Idaho	11.7	10.0	10.7	9.2	9.9	10.8	9.8	10.4	11.3	10.4	8.8
Illinois	15.7	15.2	14.8	13.9	13.6	12.4	12.1	11.7	12.1	11.6	11.3
Indiana	13.1	13.0	11.9	11.7	11.4	11.4	11.1	10.9	11.3	10.1	11.0
Iowa	12.6	10.6	11.8	10.0	10.2	8.9	8.8	9.5	8.5	9.1	8.7
Kansas	12.5	11.3	10.4	11.4	10.4	10.3	10.1	9.3	8.9	9.5	8.0
Kentucky	12.7	11.5	12.9	12.2	12.0	11.6	11.5	11.2	9.8	9.7	10.7
Louisiana	17.3	15.6	14.3	13.7	13.0	13.5	12.1	11.9	11.9	11.8	11.0
Maine	10.4	9.9	9.2	10.9	9.0	8.7	8.4	9.1	8.8	8.3	7.9
Maryland	14.7	14.5	14.0	12.6	11.9	11.8	11.8	11.9	11.7	11.5	11.3
Massachusetts	11.1	10.9	10.5	9.7	10.1	9.1	9.0	9.1	8.5	7.2	7.9
Michigan	13.8	13.3	12.8	13.1	12.1	11.8	11.7	11.4	11.4	10.7	11.1
Minnesota	12.0	10.8	10.0	10.3	9.5	9.8	8.9	8.8	9.2	8.7	7.8
Mississippi	18.7	17.6	17.0	15.4	15.4	15.1	14.4	13.7	12.4	13.7	12.3
Missouri	14.8	13.7	12.4	12.6	11.7	10.7	10.4	10.2	10.7	10.2	10.1
Montana	11.6	10.7	12.4	10.7	10.1	9.0	8.8	10.3	9.6	10.0	8.7
Nebraska	13.0	11.6	11.5	9.9	10.0	9.9	9.6	9.6	10.1	8.6	9.0
Nevada	12.5	12.5	10.7	11.2	10.2	10.7	10.5	8.5	9.1	9.6	8.4
New Hampshire	10.4	10.6	9.9	9.7	11.0	8.6	10.2	9.3	9.1	7.8	8.3
New Jersey	13.0	12.9	12.5	10.7	11.7	11.5	10.9	10.6	9.8	9.4	9.9
New Mexico	14.1	14.0	11.5	9.8	11.3	10.0	9.6	10.6	9.5	8.1	10.0
New York	14.0	13.6	12.5	12.4	12.1	11.6	11.0	10.8	10.7	10.7	10.8
North Carolina	16.6	15.1	14.5	13.1	13.7	13.2	12.4	11.8	11.5	11.9	12.5
North Dakota	13.5	11.9	12.1	11.2	10.6	8.9	8.1	8.5	8.4	8.7	10.5
Ohio	13.3	12.8	12.8	12.3	11.5	11.2	10.4	10.3	10.6	9.3	9.7
Oklahoma	14.3	12.5	12.7	11.9	12.3	10.9	11.0	10.9	10.4	9.6	9.0
Oregon	12.9	10.9	12.2	10.9	10.5	9.6	9.9	9.9	9.4	10.4	8.6
Pennsylvania	13.7	13.3	13.2	11.9	11.6	11.3	10.4	11.0	10.2	10.4	9.9
Rhode Island	13.6	14.1	11.0	11.8	10.0	11.7	9.9	8.2	9.4	8.4	8.2
South Carolina	18.6	17.1	15.6	16.1	16.1	15.0	14.7	14.2	13.2	12.7	12.3
South Dakota	13.5	11.2	10.9	11.5	10.2	10.8	10.0	9.9	13.3	9.9	10.1
Tennessee	14.8	13.6	13.5	12.6	12.0	12.8	11.8	11.4	11.0	11.7	10.8
Texas	14.3	12.9	12.2	11.6	10.9	11.1	10.5	9.8	9.5	9.1	9.0
Utah	11.4	10.7	10.4	9.8	11.0	8.8	9.1	9.6	8.6	8.8	8.0
Vermont	13.6	8.5	10.7	7.7	9.3	8.7	8.7	8.5	10.0	8.5	6.8
Virginia	13.8	14.6	13.6	12.5	12.8	11.9	12.1	11.5	11.1	10.2	10.4
Washington	12.5	11.5	11.8	10.5	10.6	9.5	10.2	10.7	9.8	9.7	9.0
West Virginia	15.1	13.8	11.8	13.0	11.4	10.9	11.0	10.7	10.2	9.8	9.0
Wisconsin	11.2	10.8	10.3	10.4	9.5	9.6	9.9	9.1	9.2	8.6	8.4
Wyoming	13.0	13.2	9.8	10.6	9.8	9.8	11.1	12.2	10.9	9.2	8.9
United States	13.8	13.1	12.6	11.9	11.5	11.2	10.8	10.6	10.4	10.1	10.0

Chairwoman SCHROEDER. Let me go first to Congressman Cramer.

Mr. CRAMER. Thank you. I just have a few quick questions based on your outstanding testimony here today.

Dr. Harmon, the Healthy Start programs, did those begin with a prior demonstration program and, if so, where did this program begin, and what kind of locations are the programs served through?

Dr. HARMON. This was developed via a task force chaired by Dr. James Mason, the Assistant Secretary for Health, that goes back almost two years. And in their proceedings, the task force reviewed the current situation and developed some options, and this targeted option was the one selected to carry forward.

It involves packaging with adequate funding, a variety of approaches that had been proven to work on a smaller scale. This would allow a community, urban or rural, to package them on a much larger scale. And it will be a five-year project, so it will be given adequate time to work. There will be a strong evaluation component before, during and after.

Mr. CRAMER. Where are some of the locations of those programs, the ones that already exist?

Dr. HARMON. Well, there are many different places that have components working well. Actually, Denver is one, in the Chairwoman's district. The Health and Hospitals organization working with a variety of federal programs provides one-stop shopping, and has one of the better infant mortality rates. That's one example.

We have various examples that we have published in monographs. Here's one we recently put out on one-stop shopping for perinatal services, where we assess some excellent sites, such as Jackson Hinds Community Health Center in Jackson, Mississippi. We need more of them.

Mr. CRAMER. Thank you very much.

Judith Jones, the program that you made reference to in Roanoke County, what is the name of that program?

Ms. JONES. It's called CHIP, which is the Child Health Investment Project, and it really is outstanding and worth taking a look at. There is a lesson to be learned there because it was a pediatrician who was well regarded by his peers, that was able to get this up and running.

Mr. CRAMER. That's to be encouraged.

And the program that you made reference to in your written statement, in Lexington, Kentucky, what is the name of that one?

Ms. JONES. It's called the Family Service Center, or Family Center, and the initiator of that project is a woman named Barbara Curry, who is the commissioner of social services, and really well worth visiting.

Mr. CRAMER. Are you familiar with the funding for that program?

Ms. JONES. You asked me the perfect question because I think program directors at the local level deserve a purple heart, at the very least. This is a mixed funding program and most successful program operators spend most of their time reporting back probably to about 15 different federal, state and local funders.

The Entrepreneurs of America are program directors at the local level. They are very effective in doing it, but it takes a really exceptional person who can tolerate that madness.

Mr. CRAMER. And with your knowledge, are these two the quick examples of good one-stop service programs?

Ms. JONES. Well, no, because actually the one in Virginia is not one-stop. Physicians are organized much more along the lines of a preferred provider organization because they agree to discount their usual fees in order to see Medicaid children. The other one is much more along the lines of one-stop.

I don't think that we're going to find, unfortunately, any one model that is going to be perfect in addressing the needs of all families in this country.

Mr. CRAMER. Thank you.

Thank you, Madam Chairman.

Chairwoman SCHROEDER. Thank you.

Congressman Bilirakis.

Mr. BILIRAKIS. Thank you.

Ms. Jones, to follow through with your last comment, you don't feel that one-stop shopping is going to do the job?

Ms. JONES. Well, you know, conceptually, it's wonderful. The question is, we don't have the system and infrastructure in place, as Kay has mentioned, and others, to be able to do that effectively. It will take time to be able to achieve that.

One-stop shopping also assumes that you have done the coalition-building and the groundwork that takes time among agencies to make that work. It would certainly be useful if, at the federal level, we could get a uniform eligibility. That would move a lot of it, I think, in the right direction, and it is something that I believe should have a higher priority.

But we go a long way from concept to implementation. Our concerns and the concerns of many people in this field is, all these great ideas are going to be thrown out there willy-nilly, and then they are not going to "work", and everyone is going to say, "You see, you can't do anything—nothing works", and there's a real danger in that.

I just visited in San Diego last week, an effort called New Beginnings, which has the attention of a number of people because it is education and welfare working together.

They have been working weekly, the Deputy Commissioner of Education and Social Services have been meeting weekly for two years. The program hasn't even been implemented yet. For a start, most agencies don't even speak the same language. They are funded under different legislation. People don't know what they are talking about. There's a certain distrust. Collaboration means sharing of limited resources. I could go down the list with you.

I would urge that while they are in the forefront and then thinking and worrying about these issues is to be applauded, let's think about what the implications are, and what do we have out there? I would suggest that a number of really serious site visits be made to various parts of the country, to see what the current situation is, before we try to glomp on a lot of new ideas. Thank you very much.

Mr. BILIRAKIS. But you do agree, do you not, that much of the problem is not being able to get the person who needs the care, to where the care is located?

Ms. JONES. Oh, no, I agree with that.

Mr. BILIRAKIS. I use the word "much" of the problem—certainly part of the problem. I like to think much of the problem, maybe not. You would know better than I.

Ms. JONES. I think that's a great deal of the problem, but I think that the mosaic of services, the patchwork that we have in federal legislation, congressional committees—I can give you a list of a lot of things that play out to the individual at the local level, but it's not only the problem in getting services, it's because people can't afford these services. We do not have universal access to health care in the United States. I mean, we could make it a lot easier for everyone to access everything if they didn't have to worry about how they were going to pay for it.

So, I don't want us to lose sight of a lot of fiscal constraints, a lot of structural constraints that make many of these ideas not work in practice, and it's important for us all to remember that and, quite frankly, to start working on some of those infrastructure issues.

Mr. BILIRAKIS. Ms. Gomez, I'm very pleased to hear about Mary's Center, and intrigued by it. It apparently seems to be working. How many such centers are there in the District of Columbia? Are there other centers such as Mary's Center?

Ms. GOMEZ. That I know of, not really like Mary's Center, no.

Mr. BILIRAKIS. Now, do you find difficulty in—you have a center. Obviously, it is not adequately funded. It's great to hear about the linkage that you have with other institutions but do you find that there are many out there who need to be served, who either do not know about Mary's Center or who, for one reason or another, do not frequent Mary's Center?

Ms. GOMEZ. Well, I don't think it's so much that people don't know about Mary's Center. As a matter of fact, I think it's totally the opposite. We are overwhelmed with people who want to come to Mary's Center, and we're not adequately funded.

One of the things that I think is interesting about Mary's Center is that it's been building out through the years. I mean, we didn't start with the philosophy that we would like to have all these services all at once, but that you start with one service, which was the maternal service, the midwifery component, and from that you build on—make it work, and then build on your pediatric, build on the WIC program, build on the Medicaid program, little by little, so that Mary's Center didn't start out with all the services all at once. Those agreements with all the agencies that we have, have been processes that have taken a very long time.

Mr. BILIRAKIS. Well, now, the problem of behavior on the part of mothers-to-be, the self-destructive behavior, the drugs, the alcohol, do you find that your center is helpful in that regard?

Ms. GOMEZ. As I said in my comments, most of the people that we see are not in the drug problems, but——

Mr. BILIRAKIS. Yes, I noticed that, too.

Ms. GOMEZ. The question you're asking, is that a problem, or is that a problem for them coming into the Center?

Mr. BILIRAKIS. No, no, that is not what I'm asking. The Center is, I guess, focused on the prenatal care and postnatal care, and neonatal. But I'm just wondering—and I hate to call it a byproduct because that's certainly a major part of the problem—but is care that you're giving also from a byproduct standpoint, helping in terms of educating some of these people regarding these other behavioral patterns?

Ms. GOMEZ. I think it was mentioned collaboratively by all of us here, that one of the things that starts off, we tend to blame the client for all the problems that they have, and one of the things that we find at Mary's Center and Healthy Babies is that, first of all, clients feel comfortable walking in there. I think anybody who has taken drugs, anybody who has any kind of problem besides just prenatal component of it, which is not really the biggest problem, is that it is an unfriendly setting, that most settings are unfriendly, most settings you wait a long time, most settings after you wait they see you for two and a half minutes and don't explain anything that has just happened to you, so that in a sense, I don't think we solve people's problems when they come into Mary's Center. I think what we do, and we like to think that we do, is that in the practice of that prenatal care, we're also expanding their knowledge of other services.

We're also looking into planning for what happens to that woman in the future. What are the family plans, not just giving them prenatal care, seeing their child and then just saying, "Next time when you're pregnant, come on in," you know. So that we're following that woman for many, many years, and not doing for her, but letting her see the services that are available and making them accessible to her.

I don't think that, again, with the one-stop shopping, that we can possibly put all the services under one roof, there's no way. My philosophy is that we need to build on more coalitions, with more agencies, to——

Mr. BILIRAKIS. I see. You would agree then, with Ms. Jones in that regard?

Ms. GOMEZ. Yes.

Mr. BILIRAKIS. Thank you.

Chairwoman SCHROEDER. Thank you.

Congressman Miller.

Mr. MILLER. Thank you, Madam Chairman. Let me just ask a couple of questions here.

Dr. Harmon, what is it that we expect the Federal Government to learn at the end of this five years? What is our response going to be to these grants after local communities make an effort to provide coordinated services, and meet the criteria to accept this funding. What is our response going to be at the end of five years, and how are we going to work with these projects?

I think Ms. Jones makes a very important point. There are a lot of collaborative efforts going on at the local level because of reduced funding. People are really stretching out to cooperate, but when they turn toward Washington, it becomes almost an impossible task, and certainly more time-consuming. So, is there going to be sort of a five-year demonstration going on back here, in how we merge these things at the end of the process?

Dr. HARMON. The evaluation, hopefully, will yield that information. We'll have each of the ten areas with an evaluation going on, but also a central one, to see how it worked across the different areas before, during and after. We hope it will work. We hope it will reduce infant mortality by up to 50 percent, and then we will know that by putting the resources into the collaboration, we can invest further to do that in more places around the United States.

Mr. MILLER. One of the things I learned on this committee is that the history of children and families is littered with demonstration programs. And usually just about the time we find out what's working and it starts to work, funding is reduced and gone, and you're almost a victim of your own success. That would be my concern here also, that the Federal Government isn't doing some self-evaluation here of how they are hindering the process. We've heard where Congressman Bliley has suggested in that commission and others—that we will spend another five years looking at model programs for people to get waivers or something from the Federal Government, and we'll now be ten years down the road. The first demonstration programs will have evaporated because funding will be cut off, and we'll be creating another means by which people can access, on a rational basis, federal funding for these very urgent needs.

Dr. HARMON. Well, we had the smaller scale programs for Maternal and Infant Care and so forth, in the '60s and '70s. Then we had the block grant, which tended to provide even more flexibility, and we didn't have a real banner or umbrella program for infant mortality, maternal and infant health. We hope that Healthy Start will become that banner. We hope that it will work, and we hope that it will be worthy of further expansion, and we hope the results start to come in relatively soon.

Mr. MILLER. Is it your expectation that Healthy Start would drive this process? I mean, is this———

Dr. HARMON. Yes.

Mr. MILLER. There's a difference between trying to meet and check all of the boxes on the application and say, "Yes, we're just like that," and that will get us funding, as opposed to the suggestion that we're trying to drive a process here that does drive the coordination, does drive the utilization of existing resources so we're not reinventing the wheel, or we're not overlooking a successful resource in the community, be it public or private. Are we really expanding—pushing back the frontiers here in this effort?

Dr. HARMON. Yes, I think we are. We agree with what you said, that this should be a driving force in those ten areas, and we hope that will be successful and can be adopted by other areas as well, where the problem is the worst. That's an important component of this. We are taking it on where it is the worst.

Mr. MILLER. Ms. Jones, is that how you view this process?

Ms. JONES. I have to think about responding to that for a moment.

Mr. MILLER. That's fair. We allow that here.

Ms. JONES. Well, because I haven't seen—I've been in California, in your state. I haven't seen all the details on this.

I think that it is important for the Federal Government to make a statement that infant mortality, at the level that we have in cer-

tain communities in America, is clearly unacceptable. I agree with that premise.

I also agree that it is important to engage larger numbers of people in focusing on this issue. I would also caution, however, that we're probably not going to learn very much after five years because we already know what works, and I don't know that we need to spend more money trying to find out what works. I think, rather, we need to intensify our efforts in getting more people that are ineligible for services, to get those services nationwide.

I hope I'll be surprised, but I don't necessarily believe that it's going to add to our body of knowledge.

Mr. MILLER. Well, that's—you ran ahead of me here. We're talking about $171 million I think many of us, when we look around our local areas, we clearly see programs that are working, but programs that are so resource-deficient that they cannot expand the universe of people that, given their history, they would be able to help either by reducing infant mortality, or low birthweight babies, or by providing better care and reducing detrimental behavior during pregnancy. Those programs are out there and have a track record, and I'm just very leery of this notion that we're going to, in a sense, be demonstrating something new. In fact, when we visit most of these areas, it's fundamental what has to be done. The question is whether, in fact, this is a diversion as opposed to very real resources in that area—I mean, how do you weigh that one?

Ms. JONES. I'm assuming that question was to you.

Dr. HARMON. Well, the new aspect of this is that it will provide a large infusion of resources into these communities, to get together the various programs to eliminate waiting lists for prenatal care, for drug abuse treatment, which are problems in many communities, to build new health centers, or to renovate buildings so that we can have more one-stop shopping sites.

One of the biggest barriers to one-stop shopping is space. I have visited the Mary's Center, and they are very cramped for space there. I've seen where a community can get a vacant building and can convince different providers to come together where it really makes a big difference—that's another thing—and to provide treatment programs for things that may not have funding now, like smoking cessation. Smoking is one of the big risk factors in pregnancy, perhaps causing 10 percent of all infant mortality, but there are no federal programs and very few state programs, to bring women into treatment for smoking cessation. And it works. It can bring down the smoking cessation rate. So, Healthy Start will provide the resources to do this, not across the country, but in ten communities. We hope that works, and we can expand from there.

Healthy Start is the umbrella that could be someday as big as some other programs. Who knows?

Ms. JOHNSON. I think it's a very important question and it's one that's been extremely troubling to me, the relative equity and the balance of resources that we're talking about in Healthy Start.

We think about it this way. The Administration is basically proposing that to solve the problem of infant mortality in ten communities is going to take $170 million annually—let's just say that's an annual figure, it may be a little more than that in some of the outyears—and at the same time, we're talking about financing all

of the rest of the maternal and child health services for the country at $570 million.

We're saying, "How much is it going to take to fix this?" Well, if we just try to fix it in ten communities, $170 million, but the rest of the country, well, the best we can do is $570 million. Now, I realize that doesn't take into account what we spend in Medicaid. I realize it doesn't take into account the investment that we make in purchasing vaccine at public sector cost, and a few other things, but remembering that Maternal and Child Health Block Grant isn't intended just to deal with infant mortality, it's also expected to provide the nurses who are going to give shots in children's arms, it's also expected to provide services for children with special health care needs, and hospitalization, and a whole range of things that are very costly.

And, so, we've really sold ourselves short in terms of thinking about how we can resolve some of these problems, and we're trying to do it on the cheap, and doing it on the cheap can't work.

Dr. HARMON. We calculate that the Federal Government spends about $7 billion a year at present, on maternal and infant programs that directly influence infant mortality. Of that, $5.1 billion is in HHS, and the vast majority is Medicaid, and another $2 billion or so in the WIC program.

Mr. MILLER. Thank you, Madam Chairman.

Chairwoman SCHROEDER. Thank you very much. Well, I wanted to ask lots of questions.

Dr. Harmon, obviously, since you've been in Denver, you know that one of the ways that we got our infant mortality rate in the city down to what it was in the suburbs was with this very expansive group of community health services. I think it's one of the models in the country, and I'm glad that you mentioned it.

There is one-stop shopping going on there now, and I'm not sure what agencies are in it. They're very concerned that at the end they are going to be designated a failure. Everything is working well except that at the end everybody is supposed to get a job for $7 an hour, and we're in a very tough time—I mean, there's hardly any jobs anywhere in Denver, Colorado right now for $7 an hour.

Can you tell me how we're going to look at things other than whether or not they get a job at $7 an hour? I'd hate to see it all proclaimed a failure for that?

Dr. HARMON. Well, that's one of the various indicators of success of programs, but there are many other indicators on that report card—high school graduation, literacy rates, various health indicators, healthy baby, healthy family, and so forth. We'll be looking at a lot of different indicators in Healthy Start—health, social service, financing indicators, how much it costs per person, and service indicators like early prenatal care, to see if we reach things like the year 2000 objectives. We have very explicit targets there, and these will be applied to the communities and we will monitor that closely.

Chairwoman SCHROEDER. So that having a $7-an-hour job won't be weighted that much. It was amazing. I talked to many of the young mothers in Denver, and they are enthusiastic. It's been wonderful, but there aren't $7-an-hour jobs for anyone, and so the whole thing gets shot down.

Dr. HARMON. That's one of many indicators. This project, since it's mainly health, will focus mainly on health indicators. But we do agree that education and employment indicators are also important.

Chairwoman SCHROEDER. Could you tell me—we heard about the Roanoke project, and one of the things we hear constantly is the fact we can't get doctors to take Medicaid patients because of malpractice concerns. Now, Medicaid patients are less apt to file for malpractice suits, I think, than anyone else.

What is Health and Human Services trying to do to get more Roanoke type situations? It seems to me, all of America should look like Roanoke. We shouldn't have to have Ms. Jones sitting here saying, "Oh, there's one place where doctors will really take patients, isn't that wonderful?" What are you doing?

Dr. HARMON. Well, we have some programs designed to get more primary care physicians and nurse practitioners, midwives and physician assistants to high-need areas in general. The National Health Service Corps is going through a big revival, with a fivefold increase in scholarship and loan repayment funding. The purpose is to get more providers out there, not just OBs, but also family physicians, general practitioners who will also deliver OB care, nurse practitioners and nurse-midwives. There's a 10-percent setaside in scholarships for those mid-level providers, and they'll be getting out there—they do not have as serious malpractice problems as OBs. When it comes to OBs, we're working with the states where a lot of legislative action has occurred on this, to promote success stories. In Missouri where I just came from, primary care doctors delivering pediatric and OB care to Medicaid or self-pay patients, zero-pay patients, now get malpractice coverage by the state legal defense fund, and that has been very successful in getting these providers back into Medicaid and back into OB care. And very few claims on that have been made.

Chairwoman SCHROEDER. So, you're pushing that nationwide?

Dr. HARMON. Yes. There's discussion of incentives for states to enact these kinds of reforms, not necessarily legal defense fund coverage, but certain limits on awards, attorneys' fees and so forth—apologies to the attorneys here—but those kinds of things are under discussion as far as incentives.

There's legislation also that's been submitted numerous times in Congress about that, although it is mostly a state matter. And we also have task forces to deal with that. The lead is by our new Agency for Health Care Policy and Research, and we work with them on this.

Chairwoman SCHROEDER. But I hope, as you look at Medicaid versus Medicare, there is such a difference in acceptability—we'd like to make it better for all—but is there anything you can do for uniformity there? That just drives me crazy, that you've got the private sector much more willing to deal with Medicare than Medicaid, and it's the same Federal Government. So, at some point, we've got a real problem.

Dr. HARMON. Sure. We work closely with the new Medicaid Bureau and the states. We're in agreement that increased Medicaid fees for obstetrics and pediatrics is a very important step. There

are now some requirements under some of the OBRA legislation, that those fees be adequate, to meet community standards.

We also now have cost-based Medicaid reimbursement for community and migrant health centers and others that look like them. That has been a big help in enhancing revenues and in recruiting and retaining more of these providers.

Chairwoman SCHROEDER. Ms. Gomez, it sounds like you're one of these new entrepreneurs that Judith Jones talked about. How do you fund your clinic and not go mad? You don't have any gray hair. How do you do it?

Ms. GOMEZ. It is a little crazy, and I think I spend probably two-thirds of my time worrying about that.

Chairwoman SCHROEDER. Two-thirds? And you have funding from foundations?

Ms. GOMEZ. Funding from foundations, D.C.—a lot of what has happened is trying to sit down with the D.C. Government and look at the issue and say, "Look, we don't think we can do it better, but I think we can do it more efficient," and trying to get funding from them, and they have been very supportive, not so much with money, but making—sort of cutting through the bureaucracy, going through WIC and not having to have that waiting period, going through Medicaid and not having to have that waiting period.

So, a lot of my time is spent trying to negotiate and say, you know, "Let's try it this way." A lot of my time is also spent showing foundations that a program like this is in the long-term, very cost-effective. The success of having done all that fundraising is that possibly we might be able to get a site, a building that somebody is going to give to us pretty soon, and I hope that comes through.

Chairwoman SCHROEDER. Well, I really salute your tenacity because I think every director of a successful program like yours tells me the same thing. They spend an incredible amount of time—there are reporting requirements, they're out trying to sell, they're out trying to do all this, and there's a long line at their door they have to turn away. If they could find some other funds, they'd be able to be out there.

So, I salute you on your being family-friendly, user-friendly, and you've got more users and families than you can serve and, hopefully, we can get all this funding stuff sorted out so it is not so complex, but thank you for being one of the new entrepreneurs who cares.

Judith Jones, I appreciate your oversight, appreciate all the things that you had to say. Let me ask a question. In every single thing we do, there is one state that shows up, that appears to be fairly enlightened on all of these, and that is Hawaii. Why is there this one bright light out in the Pacific, and the other 49 just don't get it, or one gets it here and one gets it there? I mean, I'm just astounded all across the board.

Ms. JONES. I really don't know the reason. Maybe it's because it's off-shore.

Chairwoman SCHROEDER. They haven't been contaminated by the rest of us. But wouldn't you say vis-a-vis children and health programs——

Ms. JONES. It is. In fact, they've done a number of some of the best research out there, on looking at invincibility in children in disadvantaged conditions. Maybe it's the size. I really don't know the answer to it, but it's one of the things, hopefully, we'll be able to give you the answer in about a year because we are really going to be going around the country—I will be on some of those site visits—to really take an in-depth look at not only what the program looks like on the ground, but what are the systems that allow that to happen, and what is perhaps the political history in a state that makes that happen.

I think that's very important. There is no question, too, that in this country—and I really have to mention it this morning, and I don't want it to be misinterpreted—I think that when we think of poor children, we think of minorities synonymously. And the United States has major problems with issues like that, and we have not won that war by any stretch of the imagination. It is lost on the vast majority of the population that the majority of the poor children happen to be white.

And I think that as long as we don't confront that issue in the United States, we're really not going to move on these issues because the mental image that people have about low birthweight and women on drugs certainly does not speak to the wealthy counties in Connecticut where it is almost as high in their cities as it is in the inner city in New York, and maybe higher. I think it's really important for us to understand that and confront it, or we're not going to really make the progress we need to make.

Chairwoman SCHROEDER. And Hawaii, again, seems to have overcome that. It's the only state in the union where the majority of the population is non-white. So, they've had an interesting approach to all that.

Ms. JONES. We'll have some answer, hopefully, to that because I think that's an excellent question.

Dr. HARMON. The State Health Director, Jack Lewin, is a good friend of mine out in Hawaii. I think some factors would include a lower rate of child poverty, and the economy of Hawaii is pretty strong with tourism and so forth. They now have almost universal access to health insurance——

Chairwoman SCHROEDER. And have for 17 years.

Dr. HARMON. Right, because of their employer programs and now they are filling the final gap of the unemployed.

Chairwoman SCHROEDER. Could we get you to come out for that?

Dr. HARMON. Well, the whole situation is under review. They have a strong family structure. A high percentage Asian population which tends to have better health statistics, lower mortality rates, and healthier behavior rates such as not smoking and so forth, and they have a very highly organized system with a strong state and district health departments to get all this together, and they are blessed by distinct boundaries and so forth, so it's a little easier to organize.

Chairwoman SCHROEDER. But they also—I know when I asked some of them about it—they said very smugly, "We've gotten to work on the problem rather than having big follies about it". They said, "If we'd had 'hands across America' over here, half of us would have drowned." It was a very interesting thing of how

they've been very focused on making sure the reality came. So, I hope all of us keep looking at them because they are the one state—and I just can't give them high enough accolades.

Let me ask you, what is the March of Dimes' position on the new recent reorganization of HHS, and what do you think it's going to mean for maternal and child care?

Ms. JOHNSON. We are extremely concerned. We wish, and I think there are many others in the community outside of HHS, who wish we knew a little more about the thinking of the Administration in making this decision.

Obviously, the March of Dimes and many other organizations have been saying for years, "We do need to reorganize. We do need to think about integration at the federal level." In some ways, that goes to the heart of one of Mr. Miller's questions about if we're going out there in communities and we're having Healthy Start for five years, is the Federal Government going to do something to change the way it practices simultaneously? So, it's certainly a vision that's been put forth for a long time.

I think there are several dilemmas. One is that when the proposal was made, there was discussion about moving this agency and this Administration, and then this program, and there was no indication that the important structures that supported that program were going to be brought along with it. And in some ways, I think one could look at it and say, "Is someone coming in and raiding the money," and they're not going to take the expertise and they're not going to take the structures, so that's a concern.

I think a second concern is, what does it mean to take one little piece of health, Maternal and Child Health, while this is the only exclusively devoted program to maternal and child health, it certainly in no way reflects all of the service delivery systems in maternal and child health, and take it out from under its structures, and take it out of its administration, and move it over.

If we look then at the overall structures and think about where are the other educational pieces. If this is really a comprehensive administration that's going to be put together on children and families, they ought to be looking at all of the issues that this committee looks at routinely. And it's clearly not structured in that way.

So, the administration looks more like a social welfare administration with a health piece stolen, and it's not clear to anyone at this point how the rest of those decisions are going to be made. My understanding is that there is a period when a task force is going to be convened and be meeting about the structures and the reorganization. I certainly hope there will be a lot of opportunities for public input, and input from a lot of the experts, about maternal and child health, about ways that this might work. I don't think we see it as something that couldn't categorically work, I think there are a lot of concerns about the way it's been approached and whether or not we're really taking a comprehensive view.

Chairwoman SCHROEDER. I think that's a very good point. Dr. Harmon, I guess I should go back to you and say, is this going to be comprehensive, and is it going to go to the gut of what I hear ringing in my ears from absolutely every person here, and that is, uniform eligibility, or uniform forms. I mean, this Federal Government has been fighting on paperwork. It's been the greatest politi-

cal rallying cry since I got elected, and there have been paperwork commissions, and there have been, you know, up the—but we never get it under control. Can we ever get that kind of unity and the uniform eligibility which everybody seems to be saying would sure make their lives easier.

Dr. HARMON. It's early in the process of working out the details of the new Administration for Children and Families. The vast majority of the $27 billion and 2,000 people who will be working there, are involved with social service programs such as AFDC, jobs program, child support, child care, the energy program, Head Start, child welfare, social services block grant, et cetera. The MCH Block Grant part is about a half a billion dollar part.

It is the intention to try to simplify the eligibility criteria for these various programs under one Assistant Secretary, and to better coordinate these different programs, but it is still early in the process to comment on details.

Chairwoman SCHROEDER. Well, I'm sure Kay Johnson and others are going to want to stay tuned and make sure that we don't just move the squares around, but something really transpires.

I know I've asked too many questions, but let me ask one of the final ones that just goes right to the core of my not understanding what's going on. I don't know of a state in the union where a 12-15 year old girl could walk in and say "I think I'd like to adopt a baby," where they'd say, "That's a great idea." They'd say, "You're not responsible enough. Get some schooling," and on and on and on. And yet, they can have a baby.

Now, I understand that the Administration is very sensitive about sex education because they're afraid that those who don't know about sex might take the education and then employ it, but after they've had the first child, you certainly can't have that hang-up anymore. They either figured it out or they didn't figure it out but, anyway, they had the child.

I've been very upset that we have not put family planning aggressively into any of these programs for the parent after the first child. My understanding from Ob-Gyns is that if they proceed to have another child very rapidly, they are high-risk moms, there's a great potential of more low birthweight babies, and on and on and on and on.

So, I would think that from that standpoint of infant mortality, we would be more aggressive in family planning. But it's just the one thing that keeps falling through the cracks. And then I hear the other part that Judith Jones is talking about. We now have a society that wants to say, "Oh, well, those people are just having all those babies because they want my tax money or whatever." We've got such a polarized society, they are really not looking at the real statistics on it.

Why haven't we been much stronger on that family planning component?

Dr. HARMON. We are in support of family planning. I believe the Administration has an increase in the family planning budget proposed for FY 92, and family planning is a very important component of Healthy Start. If the communities wish, they can greatly beef up their family planning programs——

Chairwoman SCHROEDER. If they wish.

Dr. HARMON. It's up to the community, it's not a requirement.

Chairwoman SCHROEDER. I just think unless you say it has to be there, it should be the client who gets to wish, and not the community. I have women following me around wanting to know how I limited it to two. I go in a family planning clinic and someone says, "Well, the community doesn't want them to know." Well, they want to know. Isn't it important that we give them the information they want to know? Why does the community have the right to veto that?

Dr. HARMON. I predict nearly all the grantees will come in proposing an expansion of their family planning programs. It's one of the best investments to improve women's health——

Chairwoman SCHROEDER. It is. It beats seatbelts.

Dr. HARMON [continuing]. Reduce infant mortality, and so we're very supportive of this.

Chairwoman SCHROEDER. Well, I would just like it to go beyond the voluntary thing because I think it really allows certain groups in the community to play with it. And I think if you go clear back to the Rockefeller report under Richard Nixon even—they talk about the importance of making it available and making it there, and not allowing people to waffle on it. And I think it would really help long term.

Dr. HARMON. And you mentioned women who have already had a child. Postpartum family planning is part of the Medicaid expansion. It's a good start, and very important. Many of the clients have already had a child. As a provider, as a local health officer in Phoenix, I saw that all the time.

Chairwoman SCHROEDER. That's right. If you try to do the sex education, everybody accuses you of running a war on puberty, but once they've had the child, I think you then put that out of the way, and that should be a component that the client picks, and not the community. So, I hope we don't give that as an option. That's what makes me very nervous about Congressman Bliley's bill, let the community pick. Well, you say you think most communities will do it, but I'm not convinced. I've gone through that battle for a long time, and I have a progressive state on this, so I know how many times you have to fight that. And I think we ought to firmly state, once someone has become a parent, they have the option to determine when to do it again, if they want to determine that, and it's not the community or someone else. So, I would hope that the Federal Government would speak loudly.

I have now done enough damage for the day, I am sure, and I apologize for keeping you all so late. Let me mention that we will keep the record open for two weeks, for any submissions or additions or whatever.

Congressman Bilirakis, thank you for hanging in here. Is there anything you'd like to add?

Mr. BILIRAKIS. No, Madam Chairwoman.

Chairwoman SCHROEDER. Thank you. Thank you to our very distinguished panel and, with that, we adjourn the hearing.

[Whereupon, at 12:40 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
6728 Old McLean Village Drive, McLean, Virginia 22101
Phone (703) 556-9222

April 23, 1991

The Honorable Patricia Schroeder
Chairwoman
Select Committee on Children, Youth and Families
385 House Office Building, Annex 2
Washington, DC 20515-6401

Dear Chairwoman Schroeder:

On behalf of the Association of State and Territorial Health Officials (ASTHO), which represents chief state health officers, I am writing to applaud you for your quick lead in holding Congressional hearings on the new Administration for Children and Families and the Healthy Start initiative. As you stated in your opening comments, placing the Maternal and Child Health Block Grant into the newly created Administration for Children and Families will certainly have a negative impact on the unity and coordination for providing children's health care services.

ASTHO has also publicly expressed its opposition to this reorganization. Enclosed is a copy of the letter sent to Secretary Sullivan. It would be appreciated if this letter could be made a part of the hearing record.

Again, thank you for responding quickly to this issue. Please let me know if ASTHO can be of any assistance to you or the Select Committee in the future.

Sincerely yours,

George K. Degnon

George K. Degnon, CAE
Executive Vice President

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
6728 Old McLean Village Drive, McLean, Virginia 22101
Phone (703) 556-9222

April 22, 1991

Honorable Louis Sullivan
Secretary
Department of Health and Human Services
200 Independance Avenue, SW
Washington, DC 20201

Dear Secretary Sullivan:

On behalf of the Association of State and Territorial Health Officials, I would like to commend you for your efforts to strengthen the administration of services for families and children. Since your briefing Wednesday to members of the Secretary's Council on Health Promotion and Disease Prevention, there has evolved a groundswell of vehement protest from state health agencies throughout the nation on one aspect of your proposal. While ASTHO and state health agencies support the efforts of the Department to focus attention upon children and families as a priority, we believe that the transfer of the Maternal and Child Health Block Grant from the Public Health Service into the new Administration for Children and Families will be a major setback to federal and state public health efforts and will adversely impact coordination of health services to children.

The announced intention of the Department to transfer this program will have a significantly negative impact upon the ability of health officials to provide quality care for pregnant women, children and infants. This transfer places a small but important health-based program among larger welfare-oriented programs; it downplays the importance of this MCH program; it threatens the integrity of child health services; it disrupts the infrastructure of maternal and child health programs; it contradicts recommendations made in the Institute of Medicine report on The Future of Public Health; it will impact on state-based models for MCH programs; it pulverizes the linkage between the block grant and the Year 2000 Health Objectives by removing the block grant from the agency responsible for monitoring the objectives; and it violates the letter and spirit of the law as adopted by Congress under Section 509 of the Maternal and Child Health Block Grant.

The placement of an important maternal and child health program within an income maintenance Administration downplays the importance of the health program and also may place it in direct conflict with a portion of the Administration's mission. Welfare-based programs, which are the significant focus of the new Administration, are driven by emphasis on screening for eligibility in order to insure that only qualified individuals participate, while public health programs have a much broader responsibility beyond just welfare eligible children and seek to address the public health needs of all women and children.

In the late 1960s, the decision was made by the Department of Health, Education and Welfare to strengthen the capacity of Federal and State agencies to address maternal and child health by moving the public health component of the Children's Bureau into the Public Health Service. This was viewed as a definitive and concrete step in focusing maternal and child health needs within the federal agency responsible for public health services. During the last 20 plus years the structure has worked well and great progress has been made in integrating maternal and child health services with other public health programs for mothers and children, such as immunization, injury prevention and lead-based poisoning prevention. This integration of services has been successful. The relocation of the MCH Block Grant to another agency, separate from the Public Health Service, will severely threaten the integrity of maternal and child health services.

Through the integration of services, it has been demonstrated that maternal and child health is more than a single service program and more than a funding mechanism; it goes far beyond simply providing preventive and primary services to low income pregnant women, infants and children. The MCH program is an integral part of the Federal/State structure designed to facilitate public health planning, epidemiology and surveillance, standard setting and quality control, data collection and analysis, and coordination of maternal and child health services with other public health programs. The infrastructure of the maternal and child health system will be compromised through the transfer of the MCH Block Grant to the new Administration for Children and Families.

The National Research Council-Institute of Medicine report on The Future of Public Health, released in 1988, emphasizes that the responsibilities of government are needs assessment, policy development and assurance. Within each state, primary responsibility for directing public health attention toward the future and implementing public health programs has been vested in a single, state level agency. Generally, the state health agency is responsible for assessing the health status of citizens within the state, setting state-wide public health priorities, carrying out national and state mandates and helping to assure access to quality health care for underserved residents. As assurers and providers of preventive health services, and as a principal provider of primary care to the medically indigent, state health agencies play a unique and important role in the American health care system. The separation of the assessment, policy development and assurance functions for mothers and children from the Public Health Service to another agency will frustrate federal and state efforts. The separation runs counter to the recommendations of the Institute of Medicine.

The Institute of Medicine Report also recommends that "public health be separated organizationally from income maintenance...." The Report argues that an emphasis on welfare payment and certification of eligibility to receive income maintenance creates a negative vision and takes away from organized efforts to strengthen public health functions. In striving to improve the

coordination of welfare-oriented services for families and children, it is the position of many in the professional community that, in fact, the forced integration of the MCH Block Grant into the Administration for Children and Families will weaken health efforts by fragmenting health policy direction at the federal level and ultimately weakening integration of health efforts at the local level. It is important to note that the Future of Public Health was developed after several years of study and after much discussion with local public health agencies and community leaders from throughout the nation.

Separation of the state portion of the MCH Block Grant from the other core functions authorized by Title V is interpreted as an attempt to fragment rather than build focused efforts on improving health status. The significance of this message is that decisions affecting public health are now being made with a conscious intent to exclude public health professionals from the process. This decision is viewed with alarm not only for its implications to the Federal structure, but also because of its potential impact upon state-based efforts to reorganize health services for mothers and children. Many states model their organizational structure after the Federal system and the consequence of moving public health out of the health departments and into welfare agencies would be devastating to state-based public health efforts. Maternal and child health services in the states are almost always delivered through local health departments or other health agencies in the community, not through welfare agencies. We support co-location of MCH services at the local delivery level, with both welfare services and other health programs, such as WIC, family planning, immunizations and disease screening but the overall management and administration of the MCH program at the federal level must remain within the Public Health Service.

The Maternal and Child Health Program has been expanding and improving annually. The Public Health Service moved to elevate the status of maternal and child health within the Health Resources and Services Administration through the creation of a new Bureau. Within the last month the success of the Maternal and Child Health Program was especially evident when it was announced that the infant mortality rate in this country has been reduced to 9.1 per thousand live births. This rate almost achieved the challenge of the 1990 health objective that there be no more than 9 deaths per thousand live births.

Achievement of the Health Objectives for the Year 2000 is an important priority for this nation's public health agencies. There are 24 other maternal and child health-related objectives within the Secretary's Health Objectives for the Year 2000. It will take a coordinated Federal/State/Local public health effort to address those objectives. In fact, in OBRA 89 legislation Congress directly linked the programs of MCH with the Health Objectives 2000 by mandating that state health departments collect data under the

MCH Block Grant regarding the Year 2000 objectives. The Public Health Service is the agency responsible for monitoring the objectives and removal of the Block Grant from the PHS is an additional impediment to the achievement of the MCH objectives.

Public health officials throughout the nation are concerned that a plan of this magnitude was implemented without appropriate discussion from all aspects of both federal and state government who deal with children and families. Decisive action is commendable. But decisive action should be based on thoughtful discussion and planning. We believe the reorganization plan - and therefore the services for children and families - might have been improved by more thoughtful coordination and planning.

Finally, Section 509 of the Maternal and Child Health Block Grant explicitly states that "The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department..." to handle a variety of responsibilities. (Emphasis added.) The statute further provides that the single, identifiable administrative unit will also provide information on "advances in the care and treatment of mothers and children" and provide technical assistance on "standards of care and evaluation," and provide direction to states on state plans, expenditures of funds and data collection. The agencies of the Public Health Service which currently provide these services work closely with state and local agencies and are recognized for their expertise in maternal and child health. The proposed reorganization plan fractionates Congressionally directed activities of one agency among multiple agencies thus leaving a deep rooted anxiety among state officials, based upon experience, that multiple federal agencies with similar responsibilities will generate confusion and provide conflicting guidance and direction. There is concern that staffing up the new child welfare agency to provide expertise in child health is redundant and unnecessarily costly.

There is every indication that the efforts of the Public Health Service in administrating the MCH program have been successful. ASTHO believes that there is no concrete evidence or justification for dismantling this effective organizational structure.

We would urge you to reconsider the placement of maternal and child health services in the new Administration for Children and Families and would appreciate the opportunity to discuss with you the impact of this announced reorganization.

Sincerely yours,

Suzanne Dandoy

Suzanne Dandoy, MD, MPH
President

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 House Office Building Annex 2
Washington, DC 20515-6401

May 7, 1991

The Honorable Thomas Bliley
U. S. House of Representatives
2241 Rayburn House Office Building
Washington, D.C. 20515

Dear Tom:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Generating Innovative Strategies for Healthy Infants and Children," held April 23, 1991. Your testimony was, indeed, important to the work of the Committee.

Congressman Frank Wolf has asked that the following questions be directed to you to add to the record:

1. You spoke at length about the need to cut through the bureaucracy and red tape that often accompanies pre- and post-natal services for pregnant women. How will your bills eliminate all the bureaucracy or duplicative categorical programs associated with prenatal care and consolidate services into one-stop shopping plans?

2. How would your bill address what seems to be one of the major barriers to women having healthy babies -- drug use during pregnancy? How would your bills deal with getting pregnant women who use drugs into treatment and prenatal care services?

It would be helpful if you would forward the answers to these questions by May 17 so that they may be included in the printed record of the hearing.

Again, my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

PATRICIA SCHROEDER
Chairwoman

PS/jg

RESPONSE FROM CONGRESSMAN THOMAS J. BLILEY, JR., TO QUESTIONS POSED BY CONGRESSMAN FRANK R. WOLF

1) You spoke at length about the need to cut through the bureaucracy and red tape that often accompanies pre- and post-natal services for pregnant women. How will your bill eliminate all the bureaucracy or duplicative categorical programs associated with prenatal care and consolidate services into one-stop shopping plans?

My solution, is a creative approach to harness the combined power of more than $7 billion to improve the health care of mothers and children. This proposal recognizes that the incremental approach to health care management for pregnant women is a barrier, not a gateway, to further reduction in infant mortality and other poor health outcomes.

This concept will eliminate barriers to comprehensive care by giving a woman immediate access to all services, from preventive services prior to pregnancy, to prenatal care including nutrition services during pregnancy, to postpartum care, all from a single provider. Delays in obtaining prenatal care will be eliminated. Children will receive immunizations, health care examinations, preventive laboratory testing, and nutritional services all in one place. Prevention will take its rightful place to reduce long-term disabilities.

Set-up is simple: The federal government would provide more than $5.5 billion to support the block grant by combining the resources of ten existing programs, including WIC, parts of Medicaid, the Maternal and Child Health Block Grant, and the Title X program. This way states will be able to determine how to best spend monies to suit their individual needs.

2) How would your bill address what seems to be one of the major barriers to women having healthy babies -- drug use during pregnancy? How would your bill deal with getting pregnant women who use drugs into treatment and prenatal care services?

My bill leaves the eligibility up to the states. Savings generated through administrative efficiencies and reduction of long-term health care expenses would enable state to expand eligibility to those suffering from drug addiction, if that was a high priority to that individual state. This is a grave problem facing many pregnant mothers, especially in urban settings. I would be more than happy to work with you, Mr. Wolf, to find the best way to most properly address this matter.

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
[illegible] House Office Building Annex 2
Washington, DC 20515-6401

May 7, 1991

The Honorable Bill Bradley
U.S. Senate
731 Senate Hart Building
Washington, D.C. 20510

Dear Bill:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Generating Innovative Strategies for Healthy Infants and Children," held April 23, 1991. Your testimony was, indeed, important to the work of the Committee.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript by May 17 with any necessary corrections.

In addition, Congressman Frank Wolf has asked that the following questions be directed to you to add to the record:

1. You spoke at length about the need to cut through the bureaucracy and red tape that often accompanies pre- and post-natal services for pregnant women. How will your bills eliminate all the bureaucracy or duplicative categorical programs associated with prenatal care and consolidate services into one-stop shopping plans?

2. How would your bill address what seems to be one of the major barriers to women having healthy babies -- drug use during pregnancy? How would your bills deal with getting pregnant women who use drugs into treatment and prenatal care services?

Again, my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

PATRICIA SCHROEDER
Chairwoman

PS/jg

Enclosure

RESPONSE FROM SENATOR BILL BRADLEY, TO QUESTIONS POSED BY CONGRESSMAN FRANK R. WOLF

1. YOU SPOKE AT LENGTH ABOUT THE NEED TO CUT THROUGH THE BUREAUCRACY AND RED TAPER THAT OFTEN ACCOMPANIES PRE- AND POST-NATAL SERVICES FOR PREGNANT WOMEN. HOW WILL YOUR BILLS ELIMINATE ALL THE BUREAUCRACY OR DUPLICATIVE CATEGORICAL PROGRAMS ASSOCIATED WITH PRENATAL CARE AND CONSOLIDATE SERVICES INTO ONE-STOP SHOPPING PLANS?

Answer: One-stop Shopping is a philosophy and strategy which can and should be applied to programs to promote efficiency and effectiveness of service delivery. There are presently many services targetted for the same population of recipients. The number of these programs has increased over time in response to identified public health needs. Yet there has been little successful effort to collaborate, often because development and implementation of the programs fall under different jurisdictions.

One of the bills which I am submitting today addresses this problem by structuring a mechanism which will enable pregnant women who are receiving Medicaid mandated prenatal services to also receive WIC program benefits through the initiative of state Medicaid programs. Not only does this legislation promote communication between the two agencies responsible for the programs, it also facilitates pregnant women getting services which are proven effective in lowering the incidence of low birthweight babies. The goal of simplifying eligibility and application processes, as well as streamlining the delivery, are inherent in each of the bills which I am submitting today.

2. HOW WOULD YOUR BILL ADDRESS WHAT SEEMS TO BE ONE OF THE MAJOR BARRIERS TO WOMEN HAVING HEALTHY BABIES -- DRUG USE DURING PREGNANCY? HOW WOULD YOUR BILLS DEAL WITH GETTING PREGNANT WOMEN WHO USE DRUGS INTO TREATMENT AND PRENATAL SERVICES?

Answer: The first step to addressing the problems and consequences of drug utilization during pregnancy is to identify the women as early as possible in order to provide supportive and rehabilitation services where available. One of the bills which I am introducing today will expand the Medicaid eligibility from the present 133 percent of the federal poverty level to 185 percent of the federal poverty level. This will provide increased access for many pregnant women to the health care delivery system and improve the effectiveness of early intervention strategies which are designed to address drug use in pregnancy and avoid the terrible consequences of drugs on the unborn child.

This is not enough. However, it is a step in the right direction. We need to have more facilities available to provide the substance abuse treatment that is necessary to assure healthy infant outcomes once the problem is identified. There are bills presently under consideration by Congress which create and expand services for drug abusing pregnant women. I support those initiatives. We must not continue to pinch penniee when tiny infant lives are at risk.

ISBN 0-16-035794-2

43-680 (139)